

THE HEALTH CARE COST CONTAINMENT ACT

HEARING

BEFORE THE

COMMITTEE ON THE JUDICIARY UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

ON

S. 2051

A BILL ENTITLED THE "HEALTH CARE COST CONTAINMENT ACT OF
1983"

JUNE 26, 1984

Serial No. J-98-131

Printed for the use of the Committee on the Judiciary



U.S. GOVERNMENT PRINTING OFFICE

WASHINGTON : 1985

41-071 O

5521-45

COMMITTEE ON THE JUDICIARY

STROM THURMOND, South Carolina, *Chairman*

CHARLES McC. MATHIAS, Jr., Maryland

PAUL LAXALT, Nevada

ORRIN G. HATCH, Utah

ROBERT DOLE, Kansas

ALAN K. SIMPSON, Wyoming

JOHN P. EAST, North Carolina

CHARLES E. GRASSLEY, Iowa

JEREMIAH DENTON, Alabama

ARLEN SPECTER, Pennsylvania

JOSEPH R. BIDEN, Jr., Delaware

EDWARD M. KENNEDY, Massachusetts

ROBERT C. BYRD, West Virginia

HOWARD M. METZENBAUM, Ohio

DENNIS DeCONCINI, Arizona

PATRICK J. LEAHY, Vermont

MAX BAUCUS, Montana

HOWELL HEFLIN, Alabama

VINTON DeVANE LIDE, *Chief Counsel and Staff Director*

DEBORAH K. OWEN, *General Counsel*

DEBORAH G. BERNSTEIN, *Chief Clerk*

MARK H. GITENSTEIN, *Minority Chief Counsel*

CONTENTS

OPENING STATEMENT

Specter, Hon. Arlen (acting chairman).....	Page 1
--	-----------

PROPOSED LEGISLATION

Text of S. 2051—A bill entitled the "Health Care Cost Containment Act of 1983"	3
--	---

CHRONOLOGICAL LIST OF WITNESSES

Muris, Timothy, Director, Bureau of Competition, Federal Trade Commission..	9
Rule, Charles F., Deputy Assistant Attorney General, Antitrust Division, Department of Justice	48
Reese, Joseph H., Jr., chairman of the board and president of Provident Indemnity Life Insurance Co., Norristown, PA, on behalf of the Health Insurance Association of America	66
Kroncke, Noel E., president, Children's Hospital, Philadelphia, PA.....	84

ALPHABETICAL LISTING AND MATERIALS SUBMITTED

Kroncke, Noel E.:	
Testimony	84
Prepared statement	90
Letter to Senator Specter, dated July 18, 1984, response to questions asked during the hearing about profit or loss of running the hospital	96
Muris, Timothy:	
Testimony	9
Prepared statement	17
Letter to Senator Specter, dated July 31, 1984, in response to questions raised during hearing	29
FTC antitrust actions in the health care services area	32
Reese, Joseph H., Jr.:	
Testimony	66
Prepared statement	70
Synopsis of bill	80
Rule, Charles F.:	
Testimony	48
Prepared statement	52

APPENDIX

Additional statements for the record:	
Washington Business Group on Health, by Willis B. Goldbeck, president...	97
Department of Health and Human Services, by Robert B. Helms, Ph.D., Acting Assistant Secretary for Planning and Evaluation	100

THE HEALTH CARE COST CONTAINMENT ACT— S. 2051

TUESDAY, JUNE 26, 1984

U.S. SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The committee met, pursuant to call, at 10 a.m., in room SD-226 of the Dirksen Senate Office Building, the Honorable Arlen Specter (acting chairman) presiding.

Staff present: Mary Louise Westmoreland, chief counsel, Subcommittee on Juvenile Justice; Stephen Cannon, chief antitrust counsel, Judiciary Committee; and Tracy McGee, chief clerk, Subcommittee on Juvenile Justice.

OPENING STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Good morning, ladies and gentlemen. This hearing of the Judiciary Committee will now begin on the consideration of S. 2051, the Health Care Cost Containment Act.

The purpose of this hearing and the proposed legislation is to explore the desirability of carving out a limited antitrust exemption which would permit certain limited activities by insurers or persons otherwise engaged in making payments with respect to health care services, to engage in certain joint activities with a view to holding down escalating costs of health care.

The statistics on the rise in cost of health care are staggering. As the statement which was submitted in advance by Mr. Joseph H. Reese, Jr., chairman of the board and president of Provident Indemnity Life Insurance Co., points out, in a nutshell: From December 1982 to December 1983, the national inflation rate averaged 3.8 percent, but the hospital room-and-board component of the Consumer Price Index rose 9.3 percent.

And health care expenditures now represent some 10.4 percent of the gross national product, or some \$362 billion a year.

Obviously the issue of health care is one of the most important matters facing the Nation today, and we have looked on a variety of solutions.

But the costs of hospital service are really just absolutely staggering.

The issue has been formulated, referring again to Mr. Reese's statement at page 8:

Some observers question why insurers do not act jointly to influence provider behavior on costs and quality of care. The answer lies in the legitimate concerns of the insurance industry that such joint action would subject it to governmental and private actions charging violation of Federal and State antitrust laws.

Whenever there is any consideration to modifying the antitrust laws, it is necessary to take a very close and a very hard look at such a subject, because the antitrust laws are so basic in our competitive free enterprise system to guarantee the benefits of competition.

So in proposing Senate bill 2051, I do so with a view to exploring the issues, without a conclusive judgment.

The statute has been crafted in a way to try to be limited, so that there can be joint action by insurers or other persons engaged in making payments with respect to charges for health care, acquiring, processing, reporting, or analyzing information, collecting and distributing insurance claims for health care service, set forth in B, or, in C, negotiating, entering into, or acting upon agreements with health care providers with respect to the utilization of health care services or the levels of charges, or reimbursement for health care services.

We know, as a matter of practice, that the Federal Government has enormous leverage in the cost which the Federal Government pays, and that the major companies, like Blue Cross/Blue Shield, have a dominant market position where they can negotiate with cost-containment views in mind on the health care provided. The private insurance industry is a vital factor in providing health care, and may well be entitled to some consideration within the context of the targetted and limited exception provided here, or in some refashioning.

And certainly as we take a look at the complexities of our industries in a lot of lines, research and development, where we are about, I think to have some exception to the antitrust rules, or we take a look at failing industries like the steel industry, or we have taken a look at what's happening in the oil industry with the mergers, or beyond in the sports field with the *Herschel Walker* case and with the Oakland Raiders, that the antitrust field is a very vital one, but we have to take a constant look at how it interacts with a great many items in the economy, and as events change.

So it is within that context that this bill has been introduced, and it is within that context that we have sought this hearing today.

At this point in the record I wish to place a copy of S. 2051.

[Text of S. 2051 follows:]

98TH CONGRESS
1ST SESSION

S. 2051

Entitled the "Health Care Cost Containment Act of 1983".

IN THE SENATE OF THE UNITED STATES

NOVEMBER 4 (legislative day, OCTOBER 31), 1983

Mr. SPECTER introduced the following bill; which was read twice and referred to the Committee on the Judiciary

A BILL

Entitled the "Health Care Cost Containment Act of 1983".

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*
3 That this bill may be cited as the "Health Care Cost Con-
4 tainment Act of 1983".

5 SEC. 2. The Congress finds that—

6 (1) the spiraling costs of the United States health
7 care system requires cooperation among various private
8 sectors to control those costs;

9 (2) the public interest requires that health insurers
10 and other payors who reimburse recipients for the ex-
11 pense of health care, or pay providers directly on

1 behalf of such recipients, be encouraged to work to-
2 gether to contain the cost to recipients; and

3 (3) the health care cost spiral appears not only to
4 be part of the national inflation in the cost of living,
5 but also to exceed other inflation rates; and

6 (4) insurers and others have cooperated in the
7 limited collection, exchange, interpretation and use of
8 data on the delivery of and charges for health care
9 services, with a salutary effect on health care costs;
10 and

11 (5) it is desirable that such cooperation continue
12 and that the right to engage in further cooperative ef-
13 forts to contain health care costs be clarified.

14 SEC. 3. As used in this chapter—

15 (a) "Health care provider" means an individual,
16 group of individuals, hospital, clinic, partnership, corpo-
17 ration, association, company, firm or any other form of
18 business enterprise which provides medical and other
19 health services, or any association of such health care
20 providers.

21 (b) "Insurer" means any individual, group of indi-
22 viduals, partnership, corporation, association, company,
23 firm or any other form of business enterprise author-
24 ized to do the business of insurance or administer in-
25 surance under the laws of the United States or of a

1 State, territory, district, or possession thereof, or any
2 association of such insurers.

3 (c) "Health care services" means any item or
4 service defined in 42 U.S.C. section 1395x (b), (c), (d),
5 (f), (g), (h), (i), (j), (m), (n), (p), (q), and (s), all as
6 amended.

7 (d) "Person" means an individual, group of indi-
8 viduals, partnership, corporation, association, company,
9 firm or any other form of business enterprise.

10 SEC. 4. The antitrust laws, as defined in section 1 of the
11 Clayton Act, and the Federal Trade Commission Act, shall
12 not apply to any activity undertaken (either directly or
13 through a third party or parties) individually by an insurer or
14 other person engaged in making payments with respect to
15 charges for health care services or jointly among such insur-
16 ers or such persons for the purpose of—

17 (a) acquiring, processing, reporting or analyzing
18 information relating to the quality, cost or utilization of
19 health care services, including reasonable and custom-
20 ary levels of charges for such services, or collecting,
21 distributing, publishing or using analyses or interpreta-
22 tions of such information;

23 (b) collecting and distributing insurance claims for
24 health care services; or

1 (c) negotiating, entering into or acting upon
2 agreements with health care providers with respect to
3 the utilization of health care services or the levels of
4 charges or reimbursement for health care services.

5 SEC. 5. (a) Activities permitted by this Act may be in-
6 vestigated at any time by the Attorney General for the pur-
7 pose of—

8 (1) determining whether the activities under inves-
9 tigation are subject to the Act; or

10 (2) determining whether such activities have had
11 the effect or will have the effect of increasing the cost
12 of health care services or unduly restricting competi-
13 tion in the delivery or financing of health care services.

14 (b) In the event the Attorney General undertakes an
15 investigation, all persons engaged in the particular activity
16 that is the subject of the investigation shall be given notice
17 thereof in writing. The Attorney General shall conduct his
18 investigation in conformance with procedures to be estab-
19 lished by him pursuant to section 553 of title 5, United
20 States Code. If the Attorney General determines after the
21 conclusion of such investigation that an activity does not
22 comply with the requirements of this Act, he shall give writ-
23 ten notice of such determination, which notice shall—

1 (1) include a statement of the circumstances un-
2 derlying, and the reasons in support of, the determina-
3 tion; and

4 (2) state with specificity any actions required in
5 order for the activity to come into compliance.

6 (c) If persons engaged in the activity under investigation
7 fail to take the actions specified by the Attorney General
8 within sixty days, he shall commence an action in the United
9 States District Court for the District of Columbia to restrain
10 and prevent the offending activity.

11 (d) In the event the district court finds that the venture
12 or program is in violation of the requirements of section 4 or
13 5 of this Act, such court shall order the cessation of such
14 activity.

15 (e) Any party aggrieved by the determination of the dis-
16 trict court may, within thirty days of such determination,
17 seek review by the court of appeals on the grounds that such
18 determination is erroneous.

19 (f) Information generated in the course of any investiga-
20 tion or court action, or submitted by any person in connection
21 therewith, shall be exempt from disclosure under section 552
22 of title 5, United States Code.

23 (g) Neither a determination by the Attorney General
24 pursuant to subsections (a) and (b), or by the district court or
25 court of appeals pursuant to subsections (d) and (e), nor any

1 statements, opinions, or recommendations issued in connec-
2 tion therewith, shall be admissible in evidence in any admin-
3 istrative or judicial proceedings in support of any claim under
4 the antitrust laws.

5 SEC. 6. This Act shall supersede any law of any of the
6 several States that might otherwise prohibit the actions au-
7 thorized within, the intent or Congress being to encourage
8 payors or health care services to assist in containing health
9 care costs.

Senator SPECTER. We are pleased to have as our lead witness the distinguished Director of the Bureau of Competition of the Federal Trade Commission, Timothy Muris.

Mr. Muris, we welcome you here. We appreciate the statement which you have submitted, and it will be made a part of the record in full.

We note your distinguished record as a professor at the University of Miami Law School, at the law and economics center there, and your having been a fellow in law and economics at the University of Chicago School of Law before that time, and having served as assistant to the Director of the FTC's Office of Policy Planning and Evaluation from 1974 to 1976.

Thank you for joining us, and we look forward to your testimony.

STATEMENT OF TIMOTHY MURIS, DIRECTOR, BUREAU OF COMPETITION, FEDERAL TRADE COMMISSION

Mr. MURIS. Thank you very much, Senator, and thank you for the opportunity to present the views of the Federal Trade Commission concerning S. 2051. With your permission, let me present an abbreviated version of my testimony and have the full version placed in the record.

Containing the cost of health care services is one of the most urgent and important tasks facing our Nation. We fully agree with the supporters of S. 2051 that health care insurers have an important role to play in cost containment. But, as I explain below, we believe that role can best be fulfilled through a healthy, vigorous, competitive rivalry among health care insurers, and not by reliance on an exemption from the antitrust laws.

Therefore, because S. 2051 appears likely to reduce the very competition among insurers that helps assure their continuing efforts to contain costs, the Commission must respectfully oppose passage of the bill.

More specifically, the Commission believes, first, current antitrust laws are no obstacle to the joint collection, analysis, and distribution of information needed for the purpose of containing health care costs. Second, collective negotiation by third-party payers with providers over health care charges and utilization—that is, over prices and output—is likely to lessen competition and may well frustrate cost containment.

An exemption for such negotiation could therefore stifle the existing and growing incentives to compete and innovate.

Let me elaborate on these two points.

The Commission has long supported the Congress traditional reluctance to grant antitrust exemptions. Special antitrust status should only be granted when there is compelling evidence that competition is unworkable or is incapable of achieving a paramount social purpose.

The Commission submits that competition has an important role to play in the provision and financing of health care services, and is playing it with increasing effectiveness.

As it became clear that the continuing escalation of health care costs must be checked, Congress and the executive branch, along with the private sector, have become increasingly interested in per-

mitting competitive forces to help provide a more efficient health care system.

The Commission has helped nurture this interest over the last decade. These efforts have focused largely on recognition that individual third-party payers have the incentive to contain costs when competing for subscribers and that the large and increasing number of physicians and other providers and hospitals with unused capacity also have an incentive to attract patients by providing cost-conscious care.

Market forces can only be successful in helping to achieve cost control, however, if vigorous competition exists among both those paying for health care and those providing it.

We think the antitrust laws can help assure that neither providers nor insurers frustrate competitive forces.

Without cost control pressure from third-party payers, health care providers often do not have the incentive to cut costs significantly. Competitive rivalry among health care insurers and other third-party payers therefore is a fertile source for cost containment. Their special relationship with both providers and consumers gives third-party payers both incentives and opportunities to reduce costs. For example, they combine innovative benefit packages, utilization review mechanisms, and financing and delivery systems.

When the market for financing is competitive, pressure to control costs will be strong, as various plans, including commercial insurers, Blue Cross/Blue Shield plans, self-insuring businesses, and HMO's, actively compete with each other in offering consumers cost-effective health care financing.

Cost containment incentives for third-party payers can be frustrated by either payer collusion or provider collusion. In the past, provider opposition has sometimes deterred insurer cost control initiatives—and in this sense we are quite sympathetic with what underlies a lot of the efforts of the insurance industry to do something about this problem.

Senator SPECTER. Well, what do you mean, Mr. Muris, by "provider opposition"?

Mr. MURIS. The Commission has issued cease-and-desist orders that halted organized provider boycotts of cost containment programs—for example, one was aimed at insurer utilization review, another was aimed at reimbursement rate decisions. We found a lot of opposition to the use of HMO's, to use of preferred provider organizations; we found professional ethical standards opposing advertising and opposing other ways to engage in effective new forms of competition.

Over the last 10 years, there have been significant efforts to promote innovative forms of competition, such as HMO's, PPO's—forms that rely on advertising, new forms of insurance. The traditional providers, sometimes hospitals, sometimes organized medicine, sometimes Blue Shield, have used the leverage that they have, through the professional associations, through the State laws, through their economic power, to thwart those new forms of competition. Those new forms of competition would lower costs, we think, and they should be encouraged. And one way to encourage

them is to use the antitrust laws to stop efforts to frustrate that competition.

Senator SPECTER. Besides limitations on advertising, what have the forms been of providers thwarting competitive circumstances?

Mr. MURIS. Well, for example, last year the Commission issued a consent agreement that dealt with a State medical malpractice insurance corporation in Tennessee where the insurance corporation—it was controlled by the traditional doctors—basically had a policy that refused to insure physicians who used independent nurse-midwives. We think a lot of the so-called allied professionals, auxiliary personnel, such as independent nurse-midwives, can be a means of reducing cost. They were being well supervised, we thought, by the doctors involved, but the insurance company had a policy of discriminating against those doctors who used independent nurse-midwives, while allowing them to use nurse-midwives as employees.

We found no basis for that distinction and therefore a new form of competition was being prevented. There is a long history, most of which fortunately has been resolved favorably in terms of HMO's, of opposition to doctors who were practicing in HMO's; for example, a practice that is now basically ended is denying hospital privileges to doctors who are engaged in innovative forms of competition, such as HMO's.

So those are some of the examples, and I would be glad to provide a more complete list, if you would like, for the record. It would take longer. The Commission has had a quite active role in this area for the last 10 years.

Senator SPECTER. Well, we would be interested in what you have found in terms of anticompetitive activities by the providers

Have you found any similar anticompetitive activities by the insurers, the payers?

Mr. MURIS. The Commission has had a long series of investigations of various practices dealing with payers, but most of our focus has been on the providers. In the sense that I am talking about, we are quite sympathetic with what underlies the purpose of your bill, which is to try to encourage innovative forms of cost containment.

But the problem that we have is twofold. First of all, under the current antitrust laws, we think that pooling and sharing of the kind of information that seems to be the thrust of your bill is legal under antitrust laws as they are now interpreted. There are some old cases which we think might give some pause, but we think the more modern cases should not. Moreover, we stand ready, as I am sure the Department of Justice does as well, to use our advisory opinion procedure—the Justice Department has a similar procedure, the business review letter process—to give guidance to insurers that want to engage in information sharing about the legality or illegality of such efforts.

Senator SPECTER. When you give those advisory letters, obviously they are not binding on the courts, if there is a challenge somewhere that those activities are violative of the antitrust laws.

Mr. MURIS. Yes, Senator, that is correct, but I don't know of any example, although there may be some in the recesses of history, where courts have disagreed with the interpretation of the Depart-

ment of Justice or the Federal Trade Commission in one of these letters.

The courts tend to defer to the agencies that are charged with enforcing the law, and in this case the antitrust laws are enforced by both the Antitrust Division and the Federal Trade Commission.

Senator SPECTER. Are you saying flatly that there is no case where any court has disagreed with such a letter from the FTC or the Department of Justice?

Mr. MURIS. I don't know of any case. The Department of Justice doesn't know of any case either.

Senator SPECTER. Would you provide a followup on that, because it is one thing to say—and I accept your representation that you know of none—but it is something different to have researched it and to have found none or to check the Department of Justice files.

Mr. MURIS. Yes, sir.

Senator SPECTER. And, of course, even in the absence of any case along that line, it's always a potential problem.

Mr. MURIS. Do you see any problem with respect to sections 4 (a) and (b) of 2051?

Mr. MURIS. Many of the new forms of innovation that have been so important in this industry have resulted because of competition, because of the fact that on the provider side there are more and more doctors, there are—some people say—an excess of hospital beds, there are more reasons to compete. On the payers' side, you've got Blue Cross/Blue Shield, you have got commercial insurers, you have got many businesses starting their own plans—and we think if you allowed the payers, the insurance companies, to get together, there would be a natural tendency to agree to have uniformity in the kind of negotiated package that they obtain from the providers. And we think that that uniformity would result in less incentive to offer the attractive mix of price and coverage that is just starting in the last several years to occur in the marketplace.

Senator SPECTER. I understand you are opposed to section C, which would provide for negotiating, entering into, or acting upon agreements with health care providers with respect to the utilization of health care services or the levels of charges and reimbursements for health care services, but what I am trying to pinpoint—you say that you have no objection, as subsection A has, acquiring, processing, reporting, or analyzing information relating to the quality, cost, or utilization of health care services, including reasonable and customary levels of charges for such services, or collecting, distributing, publishing, or using analyses or interpretations of such information—that's A.

Mr. MURIS. Well, if I could respond, we don't think in every circumstance that those activities necessarily benefit consumers. And, indeed, I take it that that is the purpose of section 5 of your bill, which is to provide a mechanism to check those activities.

We think that under current law, most situations that we could think of would be legal, and the current law already allows a mechanism to prevent those rare cases where there is an anticompetitive harm, so there is really no need, in our opinion, to add a new bill with a new standard for the Antitrust Division to apply.

And another problem with the scheme of the bill is that section 5 would remove most of the players from the antitrust field. It would remove the State attorneys general under their laws, it would remove the State attorneys general from enforcing the Federal law, it would remove the Federal Trade Commission, and it would remove the private parties. It would also remove the Department of Justice in enforcing the law, as it does now. As I read section 5, there are new standards in section 5, there are different terms of art used than the unreasonable restraint of trade standard used under the Sherman Act. Therefore, the Department of Justice would be embarking on, I take it, enforcing a different standard, and it would take a while for people to get used to enforcing and applying and interpreting that standard. I think there is no need to engage in this new effort.

Senator SPECTER. Well, that may or may not be, as to section 5, and perhaps that could be modified, or section 5 could be deleted.

But what I am trying to get is your position on a more limited approach under section 4. Section 4 has three clauses, A, B, and C, and it may be that Justice approval of the specific approach under A or B would be upheld by the courts or it might not be.

If you agree with A and B, then a question would arise why not legislate the exception of A and B and perhaps eliminate 5 altogether as to the problems you see about who is going to enforce it.

But at least to the extent that acquiring the materials and the collecting and distributing insurance claims, under B, are not undesirable as anticompetitive. Perhaps that much of an area could be agreed upon, and we could legislate as to A and B, leaving out C, or leaving out Section 5.

Mr. MURIS. Well, I think that there can be problems under A and B, so that if there was any legislation you would need some mechanism by which those problems could be addressed.

There are certain situations—I think they are very rare—in which information exchange can facilitate noncompetitive performance.

Senator SPECTER. Can you give me an example?

Mr. MURIS. Yes, sir; if you have an industry, for example, that has very few players and is very hard to enter, then providing very detailed information about costs and about various other services, about capacity, particularly if that information deals in any way with the future plans of the companies, makes it much easier for the companies to coordinate with each other—again on the assumption that we have very few players and that we have difficulty of entry.

That situation, I think, describes a few markets in health care, not all. The health care market in terms of insurance does not tend to be national because of the wide variety of State laws and local situations, so it is possible that there are situations in which the antitrust laws would, I think, be violated and you would need some enforcement mechanism.

I would suggest this as a possibility, although I don't think that we would support it: if there is really a fear among the insurance companies that the legitimate information functions which they want to address cause them undue antitrust fear, you could provide some kind of procedure which would, upon approval by the Federal

Trade Commission and Antitrust Division, immunize them from private treble damage actions, something like that. I don't think that procedure is at all necessary, but I think that if there is a fear at all that procedure would address it.

Senator SPECTER. How prompt and how complicated is it to get such an opinion from the FTC?

Mr. MURIS. Well, in the health care area, we have been responding very quickly—I would say probably within 3 months, to most of our opinion requests.

It depends in part on whether they want an opinion from just the Bureau of Competition, which I head, from the staff, or an opinion from the Commission. It usually takes a little longer to get an opinion from the Commission, but in the health care area, where we have had a lot of requests, and we have invited a lot of opinions, we have been moving quite quickly.

Senator SPECTER. Thank you, you may proceed.

Mr. MURIS. Well, I think the thrust of what we are saying is that the approach of 2051 is not an approach that we think is necessary, because it will, we think, frustrate the competitive forces that are just beginning to emerge. But we don't think that means that there is nothing that the Federal Trade Commission can do or that Congress can do; we think that the insurance industry undoubtedly wants to become more aggressive in health care cost containment, and we think that some individual insurers may be frustrated with the apparently unified front that providers present in many cases.

But we think that the fear of monolithic providers is a fear that is really out of date. We have an increased supply of health care providers. We have empty hospital beds. We have new physicians with unfilled appointment slots. We have emerging alternative forms and classes of health care providers—for example, freestanding emergency centers and ambulatory surgery centers.

Senator SPECTER. One of the difficulties which exists in the field is that there is cost shifting through the insurance mechanism, so it is not a matter where a market force, a buyer, would look over the field and would say, well, there is an empty hospital or that hospital has many beds available and their prices are lower. But if the individual is insured and the cost is shifted to the insurer, that kind of seeking out of the lower cost really isn't present, the customary market force is not presented where the insurance factor comes into play.

Mr. MURIS. But the insurance companies stand in the place of the consumer, and the insurance companies, if they are——

Senator SPECTER. But not insofar as the selection of who the provider is going to be.

Mr. MURIS. Well, but that is where we are seeing the competitive forces are really starting to make a difference, Senator, if I could elaborate for a minute.

Senator SPECTER. Please do.

Mr. MURIS. You are starting to see mechanisms building on HMO's which themselves are an important mechanism; you are seeing concepts such as PPO's, preferred provider organizations, which allow, I think, something like the HMO concept, but with a much wider choice of selection.

The consumer has an interest in obtaining an insurance policy that balances the consumer's interest in low price with high service—there is some optimal tradeoff there for consumers

And you find that consumers compete or shop for insurance. Many consumers, if not by themselves, do so through their employers, who pay for the insurance; you find a lot of interest in getting good plans.

And when the people who sell the plans have to compete with each other, then they want to sell those plans aggressively. It's competition among the people who sell the plans. If they are forced to compete with each other, the interest of buyers is in getting an attractive plan that allows market forces to work in health care the same way they work in other places. It's more complicated, because the individual consumer doesn't make that choice when he or she goes to get the medical services, but that choice is made when the insurance is purchased because the people who pay for the insurance, often the businesses, are simply not going to pay these high insurance costs any more

There has been something of a revolt among businesses in trying to reduce the greatly growing cost that you have talked about, and they are looking for cost-containment measures. And they are the people that pay, and they want competition, I believe, among the people whom they buy from.

Senator SPECTER. Well, you are postulating a situation where the people who are consumers of insurance plans are looking for the lowest cost, and then you have the issue as to how the insurance companies themselves can deal with the rising medical costs.

How do you see that working out in the competitive marketplace?

Mr. MURIS. Well, if the insurance companies, faced with these aggressive buyers, have to compete with each other, that puts upon them tremendous incentives to reduce the cost.

Senator SPECTER. How do they do that?

Mr. MURIS. Well, the way that they have been doing that is to be much tougher in their so-called utilization review, the kind of things that they pay for, to move more toward HMO's, to move more toward these preferred provider organizations that I talked about. Now, that doesn't mean that the insurance companies don't have legitimate complaints; the complaints that I mentioned before, where the providers get together and collude, is a problem; the "Blues"—the Blue Cross and Blue Shield—have traditionally received advantages from the States that I think may give them unwarranted advantages vis-a-vis the commercial insurers; Congress itself has had—

ADVANTAGES TO BLUE CROSS AND BLUE SHIELD

Senator SPECTER. What kind of unwarranted advantages do you see Blue Cross and Blue Shield having?

Mr. MURIS. Well, there have been, for example, particular tax advantages which they are given, which obviously gives them a significant advantage; they have other economic advantages because of their leverage. I think that the Congress would help the commercial insurers and help the competitive situation by going after

some of the State laws; for example, State laws that restrict PPO's and some other innovative forms Congress has taken steps to make sure that HMO innovative forms can be used. And I think that is a very helpful mechanism.

It's only been a recent step that we have embarked on in this country of trying to use competitive forces to lower health care costs, and I think that the initial readings from those steps are quite encouraging.

Senator SPECTER. Mr. Muris, let's have Mr. Charles F. Rule join us at this time. A fair amount of what he is going to testify to is going to be supplemental to what you have testified to. I would like you to stay with us, if you would, because other questions may arise that you could be of some assistance to us.

[Prepared statement follows:]

Statement of
The Federal Trade Commission
Presented by
Timothy J. Muris
Director, Bureau of Competition

Mr. Chairman, I would like to thank you for this opportunity to present the views of the Federal Trade Commission concerning S. 2051, the Health Care Cost Containment Act. S. 2051 would exempt from the antitrust laws and the Federal Trade Commission Act joint action undertaken among insurers and third-party payers of health care services relating to the collection and sharing of information and claims about such services, and also would exempt from these laws activities relating to third-party payers' joint negotiation of agreements with providers of health care services on charge levels and utilization of services.¹

Containing the cost of health care services is one of the most urgent and important tasks facing our nation. It is a task that needs the energy and commitment of all segments of the society. We fully agree with the supporters of S. 2051 that health care insurers have an important role to play in health care cost containment. But, as I explain below, we believe that role can best be fulfilled through a healthy, vigorous, competitive rivalry among health care insurers, and not by reliance on an exemption from the antitrust laws. Therefore, because S. 2051 appears likely to reduce the very competition among insurers that helps assure their continuing efforts to contain costs, the Commission must respectfully oppose passage of the bill.

More specifically, and as I explain below, the Commission believes: (1) Current antitrust laws are no obstacle to the joint collection, analysis, and distribution of information

¹ S. 2051 would do more than merely exempt certain conduct from the antitrust laws. By including the Federal Trade Commission Act in its entirety within the scope of the statutory exemption provided in Section 4 of the bill, S. 2051, if enacted, also apparently would eliminate the Federal Trade Commission's consumer protection authority over unfair or deceptive acts or practices injurious to consumers, if those acts or practices arise in the course of information collection activities by any third-party payer or other conduct immunized by the bill.

needed for the purpose of containing health care costs. Sharing information is lawful, unless it reduces competition. An exemption for such conduct therefore is unnecessary. Moreover, the broad exemption created by S. 2051 in fact could injure competition and undermine cost control by immunizing information sharing in those rare cases in which it facilitates an anticompetitive boycott or collective price-fixing. (2) Collective negotiation by third-party payers with providers over health care charges and utilization -- that is, over price and output -- is likely to lessen competition and may well frustrate cost containment, by reducing the incentive among health care insurers and other payors to compete with each other in offering consumers cost-effective and attractive insurance packages. An exemption for such negotiation could, therefore, stifle the existing -- and growing -- incentives to compete and innovate, turning "the most natural candidates for the cost-containment job,"² into uniform actors with much less reason to compete with their fellow insurers in developing and implementing the most efficient cost containment measures and benefit packages.

Competition and Antitrust in the Health Care Industry

Except as qualified by Section 5 of the proposed bill, S. 2051 would grant commercial health insurers and other persons that pay for healthcare services a special exemption from the antitrust laws. For convenience, I will use the terms "insurer" or "third-party payer" to describe the firms covered by the exemption. I want to emphasize, however, that the exemption would apply to all firms engaged in making payments for health care services. This includes commercial insurers, Blue Cross and Blue Shield plans, administrators for self-insured businesses, as well as health maintenance organizations ("HMOs") and other similar entities.³

The Commission has long supported the Congress's traditional

² Havighurst, Professional Restraints On Innovation in Health Care Financing, 1978 Duke L. J. 303, 320 (1978).

³ The bill also can be read as creating an exemption for healthcare providers. See note 12, *infra*.

reluctance to grant such antitrust exemptions, believing that "[t]he heart of our national economic policy long has been faith in the value of competition,"⁴ and that the opportunity for consumers to freely select among alternative offers generated by such competition will assure that the highest quality product is available at the best price in the marketplace.⁵ Special antitrust status should only be granted when there is compelling evidence that competition is unworkable or is incapable of achieving a paramount social purpose.⁶ The Commission submits that competition has an important role to play in the provision and financing of health care services, and is playing it with increasing effectiveness. Both the Congress and the Executive Branch have encouraged this trend toward increased competition, and have adopted several programs in the health care area that use competitive forces to improve efficiency and help control costs.

For many years competition was believed to be an inappropriate or insignificant force in the provision of health care services. Competition was discouraged among health care providers in a variety of ways, and the prevalence of third-party payment for medical expenses seemed to make the normal competitive market incentives somewhat irrelevant as the individual patient sought out medical services from the individual physician on a fee-for-service basis.

As it became clear that the continuing escalation of health care costs must be checked, Congress and the Executive Branch, along with the private sector, have become increasingly interested in permitting competitive forces to help provide a more efficient health care system. The Commission has shared and

⁴ National Society of Professional Engineers v. United States, 435 U.S. 679, 695 (1978), quoting from Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951).

⁵ See National Society of Professional Engineers v. United States, 435 U.S. at 695.

⁶ See National Commission for the Review of Antitrust Laws and Procedures, Report to the President and the Attorney General 177 (1979).

helped nurture this interest over the past decade. These efforts have focused largely on recognition that individual third-party payers have the incentive to contain costs when competing for subscribers, and that the large and increasing number of physicians and other providers and hospitals with unused capacity also have the incentive to attract patients by providing cost conscious care. Market forces can only be successful in helping to achieve cost control if vigorous competition exists among both those paying for health care and those providing it. Moreover, we believe that the antitrust laws can help assure that neither health care providers nor health care insurers frustrate those competitive forces.

Without cost control pressure from third-party payers, health care providers often do not have the incentive to cut costs significantly. Competitive rivalry among health care insurers and other third-party payers therefore is a fertile source to contain costs. Their special relationship with both providers and consumers of health care services gives third-party payers both incentives and opportunities to reduce costs -- by combining innovative benefit packages, utilization review mechanisms, and financing and delivery systems. Such innovation, however, is unlikely to happen without competitive rivalry among third-party payers. The need to attract and keep consumers through low premium levels and attractive benefits packages motivates insurers to contain costs. When the market for health care financing is competitive, those pressures to control costs will be strong, as various plans -- commercial insurers, Blue Cross/Blue Shield plans, self-insuring businesses, and HMO's -- actively compete with each other in offering consumers cost-effective health care financing.

Cost containment incentives for third-party payers can be frustrated by either payer collusion or provider collusion. In the past, provider opposition has sometimes deterred insurer cost control initiatives. The Commission has actively used its antitrust enforcement authority to prevent concerted provider opposition to cost control efforts and to remove professional restrictions limiting cost-effective care. For example, in two

cases last year, the Commission issued cease and desist orders to halt organized provider boycotts of third-party cost-containment programs, one aimed at insurer utilization review,⁷ and the other at reimbursement rate decisions.⁸ The Commission has also issued a comprehensive enforcement policy statement concerning the relationship of physician groups to medical prepayment plans and other health care insurers.⁹ In addition, the Commission has closely monitored mergers of competing hospital chains, challenging mergers that it has reason to believe are likely either to give a competitor undue market power in a market for hospital services or to increase substantially the likelihood of collusion.¹⁰ Finally, the Commission has sought to remedy several attempts by groups of fee-for-service physicians to obstruct competition from HMOs or other alternative-care institutions that employ, or contract with, physicians.¹¹

The Commission's enforcement activity, along with similar private and government antitrust actions, and the pro-competition policies of the Congress and Executive Branch, have helped create a marketplace far more receptive to cost containment efforts by health insurers -- indeed it is a marketplace that now places a premium on cost-effective insurance. Those who finance and provide health care services have responded with a refreshing

7 Indiana Federation of Dentists, 101 F.T.C. 57 (1983) (Docket No. 9118), appeal docketed, No. 83-1700 (7th Cir. Apr. 1983). See also Texas Dental Ass'n, 100 F.T.C. 536 (1982) (consent order); Indiana Dental Ass'n, 93 F.T.C. 392 (1979) (consent order).

8 Michigan State Medical Society, 101 F.T.C. 191 (1983) (Docket No. 9129); See also Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order).

9 Enforcement Policy with Respect to Physician Control of Medical Prepayment Plans, 46 Fed. Reg. 48982 (1981).

10 See, e.g., American Medical International, Inc., Docket No. 9158, F.T.C. (Initial Decision issued July 27, 1983), appealed to the Commission (decision pending); Hospital Corporation of America, Inc., Docket No. 9161 (Complaint issued July 30, 1982) (administrative hearings begun Nov. 28, 1983).

11 See, e.g., American Medical Ass'n, 94 F.T.C. 701 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982); Am. Soc'y of Anesthesiologists, Inc., 93 F.T.C. 101 (1979) (consent order); Forbes Health Sys. Medical Staff, 94 F.T.C. 1042 (1979) (consent order); Medical Serv. Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order).

array of competitive and innovative plans and institutions. One promising example of innovation by both insurance carriers and providers is the creation of preferred provider organizations (PPOs), which can offer many of the cost control features of an HMO, while giving consumers a broader choice of providers.

This era of strengthened competition is still only a few years old. Yet, it seems clear already that competition can be an important impetus for containing health care costs, because individual third-party payers and providers are reacting with flexibility and imagination to consumer demand for cost-effective services and affordable financing. We have seen no evidence that individual third-party payers are unable to meet this challenge. More might be done on the legislative front to allow competitive forces to operate freely, so that competition will be given a fair chance to give Americans affordable and accessible health care, with a minimum of government regulation. As I will discuss more fully below, now is surely not the time to obstruct this experiment in health care competition or to slow down the competitive forces for cost containment by giving insurers an antitrust exemption to act in concert, rather than individually, in dealing with the cost containment challenge.

An Antitrust Exemption for Information
Collection and Sharing Is Unnecessary

We concur with the premise underlying Section 4 of the bill that insurers and other payers may be able to implement more effectively cost containment measures if they attain access to better and more comprehensive information on the use and costs of health care services. Certainly the pooling and sharing of such information about the market could help insurers become more prudent "purchasers" of health care services on behalf of their insureds, and help insurers encourage cost conscious use of those services by both patients and providers. This type of joint information sharing activity is very likely to be procompetitive

-- and lawful under the antitrust laws as they now exist. Only in the rare situation when such an information-sharing arrangement, was shown to have been established or used to further an anticompetitive boycott or collusive price-fixing would it be condemned under the antitrust laws.

Although we can understand the desire of insurers to obtain the greater protection from possible antitrust exposure that S. 2051 would appear to provide, we strongly believe that granting such a statutory immunity would be unwise. First, as I already have stated, we believe that such joint information gathering and sharing -- if done for legitimate cost containment ends -- is almost certainly lawful under the antitrust laws. Further, both the Federal Trade Commission -- through its advisory opinion procedures -- and the Department of Justice -- through its business review letter process -- can review any such proposed joint activity and provide formal, prospective evaluations of a venture's legality. Thus the potential antitrust exposure of such joint information sharing activity by insurers is more imagined than real.

We strongly question the wisdom of granting an antitrust exemption when it is not needed on the merits, merely on the theory that it will save insurers the expense of defending against groundless lawsuits. In fact, some members of the health insurance industry have been seeking this exemption for years. Yet to our knowledge, no insurer has ever identified a single information sharing program that could not be implemented because of antitrust risk. Moreover, the statutory exemption provided by S. 2051 would appear to insulate certain joint activities that might take the form of information sharing, but which, in reality, might be undertaken for anticompetitive purposes or with anticompetitive effects. Thus, the exemption proposed by S. 2051 is not only unnecessary, but it also unintentionally could shield from the antitrust laws a variety of undesirable activities that undermine cost containment efforts.

An Exemption for Joint Negotiation by Third-Party Payers Would Harm Competition and Cost Containment

S. 2051 would exempt from the antitrust laws joint activity by insurers or other health care payers involving "negotiating, entry into or acting upon agreements with health care providers" with respect to the use of, and payment for, health care services. Although we understand that the bill seeks to facilitate cost containment by giving insurers more leverage in their negotiations with health care providers, the Commission submits that the more likely effect of the exemption will be to retard the economic incentives for each insurer to engage in vigorous cost containment by offering the public diverse, cost-effective financing in competition with other third-party payers. Economic incentives and competitive pressures are a far surer method for reducing costs than cartels or monopolies. An exemption that weakens those economic incentives is therefore more likely to frustrate than to facilitate cost containment.

As discussed above, individual third-party payers already have the clear economic incentive to encourage providers to reduce the costs of their services. Many large and small insurers and other payers have accepted this challenge and already are offering innovative, efficient packages with premiums that attract cost conscious buyers. Individual third-party payers are finding efficient providers and together they are cutting costs, thereby putting competitive pressure on other insurers and providers to do the same.

The proposed exemption, however, would allow some, most or even all third-party payers in a market to bargain jointly with providers and to agree on reimbursement levels and utilization requirements.¹² Because reimbursement levels, utilization standards, and benefit coverages are all interrelated, uniform

¹² As noted above, Section 4 might also be read to mean that providers would be immunized from antitrust liability for joint negotiating over price and utilization levels. Such an interpretation would greatly exacerbate the problems discussed above. There is little reason to believe that monopsony power for insurers will solve the cost-containment problem; there is even less reason to hope that a monopolistic combination of providers negotiating with a monopolistic combination of insurers will do so.

agreements on fees or utilization standards will encourage insurers to offer uniform products, both in benefits and prices, to the buyers of health care financing and services. Incentives will be lessened to offer a more attractive mix of price and coverage, or a better method of reducing high charges or excessive utilization levels. Competitive forces that currently reward innovation and diversity, and that result in individual insurers tailoring their products to the needs of particular segments of the public or of particular providers, will be severely reduced. In short, across-the-board coordination rather than rivalry seems hardly likely to increase overall cost-containment efforts. Uniformity rather than diversity is hardly likely to serve the needs of consumers and employers.

Section 5(a)(2) of the bill would permit the Department of Justice, under some circumstances, to seek to prevent otherwise exempt actions that "have had the effect or will have the effect of increasing the cost of health care services or unduly restricting competition in the delivery or financing of health care services." Section 5 does not adequately fill the serious void in law enforcement created by Section 4 of the bill. It provides no role for the Federal Trade Commission to prevent either antitrust or consumer protection abuses. The bill preempts the states' antitrust laws, and deprives state attorneys general of their ability to use the federal antitrust laws to prevent anticompetitive practices against their citizens. The bill eliminates criminal antitrust prosecutions for even the most egregious conspiracies in the exempted area, and it leaves private parties with no legal recourse, so that providers will have no redress for financial injury. If insurers use the exemption to negotiate with providers in ways that raise costs, consumers will have no remedy to restore their losses, even if the Justice Department eventually halts a particular practice.

In addition, the authority left to the Department of Justice is unclear. The bill may create a new legal standard -- "unduly restricting competition" -- for enforcement by the Attorney General. By contrast, the Sherman Act has been interpreted to prevent "unreasonable restraints of trade," a term that has been

judicially defined through many years of antitrust law enforcement. Section 5 also gives the Attorney General responsibility to determine whether certain activities "have had the effect or will have the effect of increasing the cost of health care services" Again, this standard differs from that employed under the antitrust laws. If the intention is for the Attorney General to determine whether health care costs are "reasonable," the result could be costly and protracted proceedings similar to those of utility regulation.

Section 5 also appears to undermine one of the apparent purposes of the entire bill, i.e., eliminating or minimizing insurers' concern that certain joint activities designed to contain costs could expose the participants to antitrust challenge and liability. Because the standards for triggering the Section 5 exception to the bill's exemption are undefined and novel, this bill will still leave insurers with considerable uncertainty about antitrust exposure.

What the Commission and Congress Can Do

The insurance industry undoubtedly desires to become more active and aggressive in health care cost containment. Moreover, some individual insurers may be frustrated with the apparently united front presented in many instances by health care providers. Although the perception of a monolithic and recalcitrant body of health care providers may, perhaps, have once had some validity, experience in the past several years shows that, in general, this simply is no longer the case.

The increased supply of health care providers -- empty hospital beds, new physicians with unfilled appointment slots, and emerging alternative forms and classes of health care providers (e.g., free-standing emergency centers, ambulatory surgery centers, etc.) -- is forcing providers to be more responsive to those who are paying for their services in order to attract patients. Purchasers, third-party payers, and providers of health care services have developed a variety of innovative programs to help control costs. Health care providers are becoming more cost conscious, and are organizing more

efficient and innovative ways to deliver health care services. Such new concepts as PPOs and primary care networks, as well as HMOs, all have benefitted or been made possible by recent changes in the supply side of the health services market. The Congress itself has greatly aided this process, both through programs to expand the supply of health care providers and facilities and through its direction and support for innovative approaches to enable and encourage the government to become a more cost-conscious, prudent buyer of health services. These efforts should be continued and expanded.

In addition, the Commission and the Department of Justice, as well as numerous state attorneys general and private parties, have actively employed the antitrust laws to prevent health care providers from stifling cost containment efforts by insurers and others. The Commission is committed to vigorously pursuing its responsibilities in this and other areas. Health care providers know this, and thus insurers should be less likely to face the concerted opposition to rigorous and innovative cost containment programs that they may once have faced. To the extent it can, the Commission also stands ready to challenge monopolistic restraints of trade by any third-party payer that unreasonably obstructs other payers' efforts to contain health care costs and compete in the market. Furthermore, as I mentioned previously, the Commission is able and willing to provide assistance, through advisory opinions and less formal advice from Commission staff, in order to help private parties avoid potential antitrust problems that might arise in their programs and activities. Continued congressional support for a strong antitrust presence in the health care area will help assure that the beneficial effects of competition attained to-date will be maintained, not eroded.

Finally, the Congress should attempt to eliminate specific, unnecessary obstacles to a more competitive health care system. Recently, the Commission endorsed removal of unwarranted state-imposed legal obstacles to the formation and operation of

procompetitive, alternative programs, such as PPOs.¹³ Not many years ago, the Congress enacted legislation to overcome state legislative obstacles that prevented the formation and development of HMOs, and to foster their development. Continued oversight and judicious congressional intervention to remove unwarranted obstacles to competition also should facilitate insurers' cost containment efforts and help obviate the need to resort to exemptions from the antitrust laws.

Thank you very much for this opportunity to express the Commission's views.

¹³ Letter from James C. Miller III, Chairman, Federal Trade Commission to Congressman Ron Wyden (July 29, 1983). See also Statement of George W. Douglas, Commissioner on Behalf of the Federal Trade Commission, Hearings on H.R. 2956: The Preferred Provider Health Care Act of 1983 Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 98th Cong., 1st Sess. (Oct. 24, 1983).



Bureau of Competition
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

JUL 31 1984

Honorable Arlen Specter
Committee on the Judiciary
United States Senate
Room 2226
Dirksen State Office Building
Washington, D.C. 20510

Dear Senator Specter:

In response to questions that you raised at hearings on S. 2051, the Health Care Cost Containment Act of 1984, held on June 26, 1984, we have assembled some additional information that we hope is responsive and helpful to you and the Committee in considering the bill.

As you recall, testifying on S. 2051 on behalf of the Commission, I stated that the Commission's advisory opinion process (as well as the Department of Justice's business review letter procedure) was available to the insurance industry in order to obtain prospective assurances of the antitrust lawfulness of proposed joint cost containment activity, such as information and data sharing arrangements. You asked whether there have been any cases where a court disagreed with a formal Commission advisory opinion relied upon by a defendant.

A combination of traditional legal research and a culling of the Commission's "institutional memory" turned up no instances in which a court had either overruled or disagreed with a Commission advisory opinion. There have been a few cases in which advisory opinions were used by private parties in an attempt to defend against antitrust challenges. All of these cases, however, involved challenged conduct different from, or going beyond, what

actually had been approved in the advisory opinions on which defendants relied. */

In my testimony on behalf of the Commission, I also emphasized that continued, active enforcement of the antitrust laws by the Federal Trade Commission and the Department of Justice, as well as by private litigants, against unlawful anticompetitive concerted actions by health care providers should help insurers engage in effective cost containment activities. You requested information on the Commission's efforts to date to prevent anticompetitive activities by health care providers. I have appended to this letter a brief summary of antitrust law enforcement activities undertaken by the Commission concerning anticom-

*/ See, e.g., *Anderson Foreign Motors, Inc. v. New England Toyota Distributor, Inc.*, 492 F. Supp. 1383 (D. Mass. 1980) (advisory opinion that a "pure" uniform delivered pricing system does not violate Section 2(a) of the Robinson-Patman Act is not a basis for concluding that a delivered pricing system does not violate the Sherman Act, or that all forms of delivered pricing systems are lawful under the Robinson-Patman Act); *Periodical Publishers' Service Bureau, Inc. v. Federal Trade Commission*, 1973-2 Trade Cas. (CCH) ¶ 74,743 (D.D.C. 1972) (issuance of advisory opinion approving industry code of conduct was not basis for enjoining Commission's issuance of complaint against individual firm, where ten of fourteen allegations in the complaint involved practices specifically prohibited by the code or not covered by it, and there was a dispute as to whether or not the subjects of the remaining allegations actually had been approved in the advisory opinion); *Morton v. National Dairy Products Corp.*, 287 F. Supp. 753 (E.D.Pa. 1968) (advisory opinion acknowledging antitrust immunity on state action grounds for dairy distributor who conformed to state-imposed mandatory price regulations did not provide a basis for finding such immunity for another distributor who voluntarily adopted distribution system making itself subject to state-imposed price floors, but instead could have adopted system that would have avoided such requirements). See also *Odessky v. Federal Trade Commission*, 471 F. Supp. 1267 (D.D.C. 1979) (initial issuance of favorable advisory opinion on promotional marketing plan did not immunize recipient of opinion from request for information about the program because of failure to meet reporting requirements under the advisory opinion and, subsequently, from formal investigation after revocation of the favorable opinion by the Commission); *United States v. Perdue Farms, Inc.*, 680 F.2d 277 (2d Cir. 1982) (issuance fourteen years previously of advisory opinions by FTC on data collection and dissemination in marketing of poultry entitled to "little weight" on issue of whether FTC or USDA had jurisdiction over certain activities, where advisory opinions did not reach issue of jurisdiction).

petitive activity by health care providers. The breadth and extent of these activities by the Commission helps demonstrate both the commitment -- and, I hope, the effectiveness -- of the Commission in helping to maintain competition in health care markets, and thereby facilitate third-party payers' cost containment efforts.

Please let me know if you have any questions or if I can provide you with further information.

Sincerely,

Timothy J. Muris
Director

Attachment

cc: Paul Guller
Chief Printer
Senate Committee on the Judiciary

FTC Antitrust Actions in the Health Care Services Area

I. Boycotts of Cost Containment Efforts by Third-party Payers

Michigan State Medical Society, 101 F.T.C. 191 (1983).

This case involved a conspiracy by the Michigan State Medical Society ("MSMS") and some of its members to boycott cost containment and reimbursement policies of Blue Cross and Blue Shield of Michigan ("BCBSM"), and the Michigan Medicaid program. Specifically, MSMS had obtained many members' authorization through a proxy campaign to collectively terminate those physicians' participation in BCBSM's and Medicaid's insurance programs if these payers did not adopt reimbursement policies acceptable to MSMS. MSMS also told its members to withdraw from BCBSM participation unless BCBSM began reimbursing physicians according to a system favored by MSMS. MSMS's actions were found to have cost BCBSM millions of dollars, leading to higher premium payments for subscribers and employers who help pay for employees' health insurance.

The Commission's order prohibits MSMS from entering into agreements on its own behalf or that of its members with third-party payers concerning the amount or terms of reimbursement, and from making threats or taking other action to coerce third-party payers to accept MSMS's or its members' positions concerning the amount or terms of reimbursement. The Commission's order permits MSMS to discuss with insurers reimbursement and other issues, provided that such discussions fall short of actually entering into agreements on behalf of members. The Commission's order also specifically states that MSMS is not prohibited from providing information to private insurance companies, or from participating in government and judicial proceedings, including those dealing with Medicaid reimbursement issues. Nor is MSMS prohibited from participating in peer review of physicians' fees.

Indiana Federation of Dentists, 101 F.T.C. 57 (1983), appeal docketed, No. 83-1700 (7th Cir. Apr. 1983).

This case, currently on appeal to the United States Court of Appeals, challenged a conspiracy of dentists to boycott dental insurers in order to obstruct the insurers' cost containment programs. Specifically, the Indiana Federation of Dentists ("IFD") had joined a conspiracy among dentists to refuse to submit to dental insurers x-rays that the dentists had already taken. The insurers used these x-rays for processing dental insurance claims, for pre-treatment authorization of coverage for proposed services, and in efforts to reduce the use of so-called "cadillac" treatment, where less expensive appropriate treatments were available. The Commission found that IFD's actions were unlawful and unfair methods of competition, and prohibited IFD from telling its

members that they should refuse to submit x-rays to insurers or "refuse to deal in any particular way" with insurers.

Texas Dental Association, 100 F.T.C. 536 (1982) (consent order).

This consent agreement settled allegations that the Texas Dental Association ("TDA") had engaged in an unfair method of competition by boycotting dental insurers. Specifically, TDA was alleged to have induced its members to refuse to provide diagnostic aids, including dental x-rays that the dentists had already taken, to insurers who needed them to determine benefits prior to treatment, as part of their cost containment programs. TDA allegedly conducted meetings and pledge card campaigns to obtain members' support and adherence to guidelines concerning how members would deal with insurers. Further, TDA is alleged to have insisted that insurers agree to follow claims processing procedures imposed by TDA. The consent order prohibits TDA from conspiring with its members to boycott cost containment efforts by insurers who request x-rays the dentists have already taken. The order does not require any dentists to take any x-rays.

Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order).

This consent agreement settled allegations, among others, that the Association of Independent Dentists ("AID") had engaged in unfair methods of competition by acting as a combination of, or by conspiring with, at least some of its members to restrain competition among dentists in Pueblo County, Colorado, by taking collective action to increase the level of reimbursement paid for dentists' services by third-party payers. Specifically, AID was alleged to have agreed with its members to deal with third-party payers as a group in order to force an increase in reimbursement levels paid for dental services. In furtherance of the agreement, AID was alleged to have threatened a third-party payer with a collective refusal to deal by its members.

The consent order prohibits AID from threatening or coercing third-party payers to accept positions taken by AID concerning reimbursements paid for dental services.

Indiana Dental Association, 93 F.T.C. 392 (1979) (consent order).

This consent agreement settled allegations that the Indiana Dental Association ("IDA"), its component societies, and its members had conspired to frustrate dental insurers' cost containment provisions. Specifically, the Commission's complaint alleged that IDA and its 14 component societies had organized members to refuse to submit dental x-rays, which the dentists had already

taken, to dental insurers who used such x-rays to determine benefits. Many dental insurance programs in Indiana apparently provided for determination of benefits in advance of treatment and limited benefits to the least expensive adequate course of treatment, as determined by a review of x-rays and other materials. The consent order prohibits IDA from urging its members to refuse to submit dental x-rays to insurers. Further, IDA is prohibited from compelling or coercing any insurer to modify its dental benefits programs.

II. Restraints on HMOs and Other Forms of "Contract Practice"

American Medical Association, 94 F.T.C. 701 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 455 U.S. 676 (1982).

The Commission, among other things, ordered AMA to stop restricting the types of contractual arrangements that physicians may enter into with organizations that offer physicians' services. The restrictions, imposed through AMA's ethical code, included a prohibition on physicians working on a salaried basis or for below "usual" rates for hospitals, HMOs, and other "lay" institutions.

Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order).

The Commission prohibited the medical staff of a system of hospitals (Forbes) from preventing or obstructing physicians affiliated with closed-panel HMOs from obtaining hospital privileges at hospitals in the system. The challenged conduct, which included denying or unduly delaying medical staff applications from physicians affiliated with an HMO or practicing on other than a fee-for-services basis, allegedly hindered the creation and growth of HMOs as a source of competition for members of Forbes medical staff.

American Society of Anesthesiologists, Inc., 93 F.T.C. 101 (1979) (consent order).

The Commission prohibited the American Society of Anesthesiologists, Inc. ("ASA"), a national medical specialty association, from threatening or engaging in coercive conduct in order to restrain any anesthesiologists from practicing on other than a fee-for-service basis. ASA also agreed not to condition membership privileges on the compensation arrangement of any anesthesiologist. ASA allegedly had conspired with its component societies and members to enforce ethical restrictions and official ASA policy that required anesthesiologists to practice only on a fee-for-service basis, and not as salaried employees of organizations such as hospitals.

Medical Service Corp. of Spokane County, 88 F.T.C. 906 (1976) (consent order).

The Commission prohibited a Blue Shield Plan (Medical Service Corporation of Spokane County, Washington) and an affiliated physicians' association (Medical Service Bureau of Spokane County) from discriminating against physicians associated with HMOs or who practice on other than a fee-for-service basis. The medical service corporation and the medical service bureau allegedly conspired to boycott and interfere with the creation and growth of HMOs in eastern Washington by excluding physicians who provided services to HMOs from becoming participating physicians in the medical service bureau. The medical service bureau, which had subscriber enrollment of more than twenty-five percent of the population of eastern Washington, would only pay for medical services rendered to subscribers if those services were performed by a "participating" physician.

III. Pricing Activity, Including PPOs

Health Care Management Associates, 101 F.T.C. 1014 (1983) (advisory opinion).

In June of 1983, the Commission issued an advisory opinion that a proposed preferred provider organization ("PPO") program, which would restrict participation to a limited percentage of local area physicians, would not violate the antitrust laws. Under the program, subscribers and beneficiaries would have financial incentives, through waiver of coverage deductibles and co-payments, to use the identified, selected providers, who would offer discounted fees to the program. The Commission, in its advisory opinion, concluded that operation of the proposed program would not constitute price fixing or an unlawful joint sales agency arrangement, nor would it raise questions of boycott or concerted refusal to deal, or monopolization. The Commission noted the program's potential procompetitiveness by generating competition between cooperating providers and other providers, and among third-party payers.

Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48,982 (1981).

After a comprehensive investigation of control of medical prepayment plans by physicians and physician organizations, the Commission issued a statement of enforcement policy discussing the circumstances under which abuse of such control may violate the antitrust laws. The statement is intended to facilitate voluntary compliance with the antitrust laws by physician groups and medical prepayment plans. It explains that when prepayment plans with market power are controlled by physician groups, the antitrust laws would be violated if the effect of such control is either

supra-competitive or artificially inflated fees to doctors, or if nonphysician health care providers are unreasonably excluded from reimbursement by the plan.

Association of Independent Dentists, 100 F.T.C. 518 (1982) (consent order).

See discussion in Section I, above.

California Medical Association, 93 F.T.C. 519 (1979) (consent order); Minnesota State Medical Society, 90 F.T.C. 337 (1977) (consent order); American College of Radiology, 89 F.T.C. 144 (1977) (consent order); American Academy of Orthopaedic Surgeons, 88 F.T.C. 968 (1976) (consent order); American College of Obstetricians and Gynecologists, 88 F.T.C. 955 (1976) (consent order).

The Commission issued consent orders in five cases between 1976 and 1979 settling complaints that challenged the use of "relative value scales" by medical societies. A relative value scale is a list assigning numerical values to various medical and surgical services, so that the "value" of different services can be compared. Relative value scales are used by doctors to construct a fee schedule by multiplying the value of different procedures by a "conversion factor." Relative value scales published by medical societies can facilitate price fixing among doctors and lessen competition by rigidifying pricing structures.

In each of these five cases the complaints charge that the medical societies adopted relative value scales and distributed them to members, and that use of the relative value scales served to establish or maintain the fees charged by physicians. The California Medical Association allegedly also provided its members with instructions on how to convert its relative value scale into a fee schedule. In Minnesota State Medical Society, local medical societies allegedly recommended conversion factors for their members' use in conjunction with the society's relative value scale.

Each of the consent orders essentially required the medical society to repeal and recall its relative value scale and prohibited the society from developing relative value scales or advising its members or others to use or not to use any existing or future relative value scales. The orders do not prohibit the medical societies from supplying information requested by government bodies or third-party payers (so long as information bearing on fees is limited to data on fees actually charged in the past), and the orders do not interfere with development or use of relative value scales by third-party payers or with legitimate peer review activities by medical societies.

IV. Peer Review

American Medical Association, 94 F.T.C. 701 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 455 U.S. 676 (1982).

The final order in this case, which dealt with the AMA's ethical code restraints on advertising and contract practice by physicians, expressly states that it imposes no restriction on professional peer review activities.

American Podiatry Association (FTC staff advisory opinion letter issued Aug. 18, 1983).

The FTC Bureau of Competition staff issued an advisory opinion letter that a proposed peer review program of the American Podiatry Association ("APA"), for use by APA's fifty-two component societies, does not violate the antitrust laws. Under APA's proposed Guidelines for peer review programs, third-party payers and podiatrists may request component societies' peer review committees to review their particular disputes regarding quality of podiatric services, necessity of care, and fee levels. Program participation is voluntary and determinations are not binding unless the parties have freely agreed among themselves to be bound. The peer review determinations will not be generally released beyond the participants to the dispute unless the law otherwise requires.

The Bureau staff opinion noted that APA's intent in designing the program and recommending that its component societies undertake peer review activities does not appear to be anti-competitive, and that the voluntary nature of the program and its procedural safeguards make it unlikely that the peer review process could be used to coerce parties into adopting APA's or its component societies' policies, or to facilitate price fixing, boycotts or other anticompetitive conspiracies. The opinion noted that the program may benefit competition and help reduce health care costs.

Rhode Island Professional Standards Review Organization, 101 F.T.C. 1010 (1983) (advisory opinion).

The FTC issued an Advisory Opinion that the proposed peer review program of the Rhode Island Professional Standards Review Organization ("RIPSRO"), an organization of Rhode Island doctors performing peer review for private employers' health benefits programs, does not violate the antitrust laws. Under the peer review program, RIPSRO would review candidates for elective surgery, both prior and subsequent to admission; review in-hospital health services and hospital admissions and discharges; recommend appropriate length of hospitalizations; and perform quality review

studies. RIPSRO's recommendations would not be binding and would not include review of fees.

The Commission opinion advised that the program does not involve any price fixing, concerted refusal to deal, agreement not to compete, or conspiracy in restraint of trade. The Commission noted the program could promote competition and cost containment because an insurer or employer could use the program's information in deciding whether to pay for a patient's medical care, and consumers could use it in deciding whether to purchase services. The Commission cautioned that the program not be used illegally as a price fixing mechanism or means of coercion against competitors instituting innovative but legitimate practices.

Iowa Dental Association, 99 F.T.C. 648 (1982) (advisory opinion).

The FTC issued an Advisory Opinion to the Iowa Dental Association ("IDA") stating that a proposed dental fee review program by the Association and its component dental societies would not violate the FTC Act unless abused. Under IDA's proposed program, members of local dental societies would provide nonbinding guidance as mediator in disputes between dentists and patients or dentists and insurers on whether a fee is excessive or appropriate in a particular case.

IDA was advised that guidance given by a major professional society can become coercive if the voluntary and advisory nature of the program is not perceived by all participants. Antitrust concerns would also be raised if the program were used to determine whether fee schedules or reimbursement programs were sufficient, or if dental society members collectively set "usual" or "customary" fees. Further, the program could be subject to anti-trust challenge if it were used to discipline dentists for innovative, competitive practices.

The Commission suggested safeguards to ensure that the program is not used as a price fixing mechanism or means of coercion, and explained that care must be taken to ensure that the program remains legitimate and does not produce significant anti-competitive effects. The Commission suggested that having consumer representatives serve on the review panels could help ensure that patient-dentists disputes are resolved in an evenhanded manner.

V. Restraints Against Nonphysician Health Practitioners

State Volunteer Mutual Insurance Co., No. C-3115
_____ F.T.C. _____ (consent order issued September 28, 1983).

This consent order settles charges that State Volunteer Mutual Insurance Company ("SVMIC"), which provides malpractice

insurance to about 80 percent of Tennessee's physicians, had conspired with its member physician policyholders to restrain competition among physicians and nurse midwives in Tennessee by denying malpractice insurance to physicians who supervise independent nurse midwives and that its actions constituted a boycott and unfair methods of competition. The complaint alleges that two self-employed nurse midwives who were licensed by the State of Tennessee and certified by the American College of Nurse Midwives had arranged, as state law requires, for a licensed physician to act as their medical consultant and back-up physician. Although SVMIC provided insurance to physicians who employ nurse midwives, it cancelled the supervising physician's malpractice insurance, basing its decision on the purported ground that undue risk would be an inherent result of the economic relationship between the two nurse midwives and the physician. The complaint charged that SVMIC had no reasonable or substantial basis for discriminating between physicians who supervise independent nurse midwives and physicians who employ nurse midwives.

This consent order prohibits ("SVMIC") from discriminating between physicians who are affiliated with economically independent nurse midwives and physicians who employ nurse midwives. The order also prohibits discrimination without a reasonable underwriting basis between physicians who are affiliated with nurse midwives and those who are not affiliated with nurse midwives.

Statement of Enforcement Policy With Respect to Physician Agreements to Control Medical Prepayment Plans, 46 Fed. Reg. 48,982 (1981).

See discussion in Section III, above. The statement, among other things, discusses how a medical prepayment plan controlled by physician groups or organizations might violate the antitrust laws if it unreasonably excludes nonphysician health care providers from reimbursement by the plan.

VI. Restraints on Advertising

American Medical Association, 94 F.T.C. 701 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 455 U.S. 676 (1982).

The Federal Trade Commission issued a complaint in December 1975, alleging that the American Medical Association had conspired with affiliated state and local medical societies to limit competition among physicians by imposing certain ethical restrictions on their members. The restrictions included, among other things, a prohibition on physician advertising and solicitation, which suppressed the distribution of truthful information about physicians' services.

The case was heard by an FTC Administrative Law Judge who found that all of the restrictions were unfair methods of competition. The advertising restriction was also found to be an unfair act or practice injurious to consumers and violating the public policy favoring the free flow of truthful commercial information. The full Commission affirmed that decision and entered an order against the AMA in 1979. The FTC order was upheld by the United States Court of Appeals for the Second Circuit in 1980, and was affirmed by an equally divided Supreme Court on March 23, 1982.

The FTC order, among other things, requires the AMA to stop prohibiting truthful advertising by its member. It also requires the AMA to disaffiliate any state or local medical society that it learns is engaging in activities prohibited by the order. The order expressly permits the AMA to issue reasonable ethical guidelines prohibiting advertising that it has reason to believe is false and deceptive.

American Dental Association, 100 F.T.C. 448 (1982) (consent order).

The Federal Trade Commission issued a complaint against the American Dental Association ("ADA") and four of its affiliated state and local dental societies in 1977 challenging ethical restrictions imposed on their dentist members that prohibited truthful advertising. ADA and the four dental societies signed a consent agreement in 1979 lifting the restrictions, and a remedial order was issued by the Commission permitting ADA to maintain ethical standards against false and deceptive dental advertising. The Commission's principal charge, "unfair methods of competition," was premised on the antitrust illegality of agreements not to compete through advertising. "Unfair acts or practices" were also alleged, based on the consumer injury resulting from restraints on dissemination of truthful information on the price and availability of dental services.

The consent order provided that the provisions of any final order entered in the similar American Medical Association proceeding would be applicable to the respondents in the ADA case to the extent they deal with advertising. The Commission's order in the AMA matter went into effect in May of 1982. A final consent order which conformed to the AMA order was issued in ADA on August 3, 1982 (47 Fed. Reg. 36,184 (1982)). The order prohibits the ADA from restricting truthful advertising of dental services, but permits it to enforce reasonable ethical guidelines against advertising it has reason to believe is false or deceptive. As a condition of affiliation with ADA, state and local dental societies must pledge not to restrain truthful advertising.

Michigan Association of Osteopathic Physicians and Surgeons,
No. C-3112, ____ F.T.C. ____ (consent order issued July 26,
1983).

This consent order settled charges that the Michigan Association of Osteopathic Physicians and Surgeons had conspired with its members to restrain competition among osteopathic physicians and surgeons in Michigan by prohibiting its members from truthfully advertising their services and that its actions constituted unfair methods of competition. According to the Federal Trade Commission's complaint, the Association, a professional organization of osteopathic physicians and surgeons and a divisional society of the American Osteopathic Association, Inc., had enacted an ethical code prohibiting members from truthfully advertising their services. The complaint alleged that the Association threatened to take disciplinary action to compel members to cease advertising and attempted to prohibit sellers of advertising space from accepting the truthful advertisements of its members. The complaint further alleged that these actions frustrated or eliminated competition among osteopathic physicians and surgeons and deprived consumers of the benefits of such competition and the receipt of truthful information regarding osteopathic physicians' services.

Under the consent order the Association agreed not to restrict, regulate, advise against, or interfere with the advertising of osteopathic physicians' services. The Association is not prohibited from adopting and enforcing reasonable ethical guidelines governing the conduct of its members with respect to representations that the Association believes are false and deceptive or with respect to in-person solicitation of patients vulnerable to undue influence.

Broward County Medical Association, 99 F.T.C. 622 (1982)
(consent order).

This consent order prohibits the Broward County (Florida) Medical Association ("BCMA") from restraining truthful advertising by its members. The Federal Trade Commission complaint alleged that through 1981 BCMA enforced a code of ethics prohibiting truthful advertising by its members of information useful to patients. For example, senior citizens were deprived of information about which physicians accept Medicare payments as payment in full, and other consumers were deprived of information on physicians' fees, professional training and experience, their knowledge of languages other than English, and their willingness to accept credit cards. The complaint also charged that BCMA threatened disciplinary action and other sanctions against members who advertised, and intimidated physicians who wanted to truthfully advertise.

The final order is similar to an order the Commission issued in 1979 against the American Medical Association. The consent

agreement permits BCMA to adopt and enforce reasonable ethical guidelines governing false and deceptive advertising as well as in-person solicitation of patients who, because of their circumstances, are vulnerable to undue influence.

Washington, D.C. Dermatological Society, No. C-3118,
_____ F.T.C. _____ (consent order issued Oct. 5, 1983).

This consent order settled charges that the Washington, D.C. Dermatological Society had conspired with its members to restrain competition among dermatologists in the Washington metropolitan area by prohibiting its members from truthfully advertising their services. According to the complaint, the Society, a professional association of physicians who limit their practices to dermatology and are Diplomates of the American Board of Dermatology, had enacted an ethical code prohibiting its members from truthfully advertising their services. The complaint also alleged that the Society threatened to deny membership to physicians associated with health care delivery organizations that advertise the identity, fees, or services of associated physicians. The complaint alleges that these actions frustrated or eliminated competition among dermatologists and deprived consumers of the benefits of such competition and the receipt of truthful information regarding dermatologic services.

Under the consent order the Society agreed not to restrict, regulate, advise against, or interfere with the advertising of dermatologic physicians' services or the advertising by health care organizations of associated physicians' services. The Society is not prohibited from adopting and enforcing reasonable ethical guidelines governing the conduct of its members with respect to representations that the Society believes are false or deceptive or with respect to in-person solicitation of patients vulnerable to undue influence.

Association of Independent Dentists, 100 F.T.C. 518 (1982)
(consent order).

This consent order, discussed more fully in Section I, above, also settled allegations that the Association of Independent Dentists ("AID") had acted as a combination of, or in conspiracy with, at least some of its members to restrain competition among dentists in Pueblo County, Colorado, by restricting truthful advertising of their services by AID's members. Specifically, AID enacted bylaw provisions prohibiting the advertisement of members' dental practices without obtaining prior approval from AID's Board of Directors.

The consent order prohibits AID from restricting the advertising of dental services.

VII. Professional Ethics

American Academy of Ophthalmology, 101 F.T.C. 1018 (1983) (advisory opinion).

On June 17, 1983, the FTC issued an Advisory Opinion to the American Academy of Ophthalmology ("Academy"), an organization of physicians specializing in medical and surgical eye care, that its proposed code of ethics to govern the professional conduct of its members does not violate the antitrust laws.

The Academy was advised by the Commission that the antitrust laws do not prohibit professional associations from adopting reasonable ethical rules designed to protect the public, and that such self-regulatory activity that serves legitimate purposes can benefit competition and consumer welfare. The Commission noted that the legality of a professional society's ethical code under the antitrust laws depends upon its purposes and competitive effects.

The proposed code contains three sections: non-enforceable "Principles of Ethics," specific, enforceable "Rules of Ethics," and "Administrative Procedures" for the Academy's Ethics Committee and investigative and disciplinary proceedings. The Commission opinion advised that the Principles of Ethics and Administrative Procedures of the proposed code do not violate the antitrust laws, and that while most of the Rules of Ethics do not raise significant antitrust issues, four of the Rules, because of the nature of the restraints imposed, could in application cause antitrust problems. The Commission discussed the antitrust concerns which could arise from the code provisions which address clinical experiments and investigative procedures, delegation of ophthalmological services, postoperative care, and communications to the public.

The Commission advised that, based on the information provided it, including the stated aim of the Academy to assure that the code is interpreted and enforced objectively and fairly, and the flexibility of the Rules provisions, adoption of the Code of Ethics would not violate the antitrust laws.

American Medical Association, 94 F.T.C. 701 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 455 U.S. 676 (1982).

See discussions in Sections II, IV, and VI, above.

American Society of Anesthesiologists, Inc., 93 F.T.C. 101 (1979) (consent order).

See discussion in Section II, above.

American Dental Association, 100 F.T.C. 448 (1982) (consent order).

See discussion in Section VI, above.

Michigan Association of Osteopathic Physicians and Surgeons, No. C-3112, ____ F.T.C. ____ (consent order issued July 26, 1983).

See discussion in Section VI, above.

Broward County Medical Association, 99 F.T.C. 622 (1982) (consent order).

See discussion in Section VI, above.

Washington, D.C. Dermatologic Society, No. C-3118, ____ F.T.C. ____ (consent order issued Oct. 5, 1983).

See discussion in Section VI, above.

VIII. Anticompetitive Hospital Mergers

American Medical International, Inc., Docket No. 9158, ____ F.T.C. ____ (Commission decision issued July 5, 1984).

On July 30, 1981, the FTC filed a complaint charging that the acquisition of French Hospital in San Luis Obispo, California, by American Medical International, Inc. ("AMI") may have the effect of substantially lessening competition or tending to create a monopoly in San Luis Obispo City and County, and constitutes an unfair method of competition. The complaint further charged that AMI, with specific intent to exclude competition and maintain power to control delivery of hospital services, attempted to monopolize the hospital services market in the area. Specifically, in July 1979 AMI, the third largest proprietary hospital chain in the United States, purchased French Hospital, an acute care hospital in San Luis Obispo City and County, California. Prior to this purchase, AMI owned one hospital in San Luis Obispo City and also had previously purchased another hospital in the area. The complaint alleged that French Hospital competed with AMI's hospitals in San Luis Obispo City and County and that the acquisition increased the market concentration for hospital services in the area and gave AMI substantial market power.

Hearings in this matter were held before an Administrative Law Judge. In his Initial Decision, the ALJ found against AMI on the charges made in the complaint. The ALJ found that AMI's market shares and the high market concentration for hospital services in the area gave AMI a dominant place in a market that has

high barriers to entry because of state certificate-of-need laws. He also found that AMI acquired French Hospital with specific intentions of monopolizing the local market so it could "control" the market and end the "struggle" in the market for patients.

The ALJ issued an Initial Decision and entered an order against AMI on July 27, 1983, requiring AMI to divest French Hospital within one year. The order also required AMI to seek prior FTC approval for acquisitions of hospitals in 13 states where AMI already owns or operates hospitals when AMI pays more than one million dollars per hospital and its resulting share of the beds in the local area would be 20 percent or more.

AMI appealed the ALJ's decision to the Commission, which issued its decision and order on July 5, 1984. The Commission's decision upheld most of the ALJ's Initial Decision, requiring divestiture by AMI. However, by a 3-2 vote, the Commission eliminated the requirement of prior approval for certain future hospital acquisitions by AMI, and instituted a provision requiring prior notification by AMI of certain hospital acquisitions. The Commission also did not rule on the issue of whether AMI had attempted to monopolize the market.

Hospital Corporation of America, Inc., Docket No. 9161
(complaint issued July 30, 1982) (administrative hearings begun Nov. 23, 1983).

On July 30, 1982, the Federal Trade Commission issued a complaint charging that the acquisitions of two hospital chains by Hospital Corporation of America, Inc. ("HCA") may have the effect of substantially lessening competition or tending to create a monopoly in Chattanooga and the surrounding region, and that the acquisitions constitute unfair methods of competition.

The complaint alleges that in August 1981, HCA, the largest proprietary hospital chain in the United States, purchased Hospital Affiliates International, Inc. ("HAI"). HAI had owned one acute care hospital and managed another in Chattanooga, Hamilton County, Tennessee, and managed a third acute care hospital in another city in Hamilton County. HAI also owned one acute care hospital and managed another acute care hospital in counties located in the same Health Service Area ("HSA") as Hamilton County. In December 1981 HCA purchased Health Care Corporation ("HCC"). HCC had owned an acute care hospital and a psychiatric hospital in Chattanooga. Prior to these acquisitions, HCA had owned an acute care hospital in Chattanooga and two acute care hospitals in counties located in the same HSA as Hamilton County.

The complaint alleges that these acquisitions were of HCA's direct competitors for hospital care services in Chattanooga, Hamilton County, and the surrounding area, and that the acquisi-

tions increased the market concentration for hospital services in that region. The complaint charges that the effects of the acquisitions may be to substantially lessen competition or tend to create a monopoly in the hospital services market in Chattanooga and the surrounding area.

The case currently is at the stage of post-trial briefing by counsel, prior to consideration of the record and issuance of an initial decision by the Administrative Law Judge before whom the case was heard.

IX. Hospital Privileges, Including Exclusive Contracts Burnham Hospital, 101 F.T.C. 991 (1983) (advisory opinion).

Burnham Hospital, a general acute care hospital in Champaign, Illinois, has a contract with a group of radiologists which grants to the group the exclusive right to provide radiological services to the patients in Burnham Hospital. Burnham Hospital questioned whether any of the antitrust laws enforced by the Commission would be violated if Burnham, acting pursuant to the contract, denied access to its radiology facilities or authorization to provide radiology services to patients at Burnham, to a physician not affiliated with the radiology group operating under contract to the hospital.

The Commission stated in its Advisory Opinion that it believes the Burnham contract does not represent the type of naked restraint of trade to which the per se rule of illegality applies, but that it should be judged under the rule of reason which focuses on whether the contract's effects on competition among radiologists and among hospitals are on balance harmful or beneficial. Burnham was advised by the Commission that an exclusive contract for radiology services can have anticompetitive aspects because such a contract limits the ability of the patient and the attending physician to choose among competing radiologists and makes it more difficult, if radiologists contract in groups, for individual physicians to enter the market since a physician may have to join an existing group or form a new group in order to practice in the area. However, an exclusive contract of reasonable duration does not eliminate competition among radiologists or prevent entry, but instead shifts the focus of competition among both established and entering radiologists to the securing of the contract. An exclusive contract may also be procompetitive by providing a number of benefits to hospitals and to patients. At least in some circumstances, such contracts can facilitate the efficient delivery of services. To the extent that these procompetitive effects are realized, a hospital is better able to compete with other hospitals.

Based on the information available to the Commission, the Commission advised Burnham that it does not appear on balance that Burnham's adherence to its contract with the radiological group

under exclusive contract would violate any of the antitrust laws enforced by the FTC.

Forbes Health System Medical Staff, 94 F.T.C. 1042 (1979) (consent order).

See discussion in Section II, above.

Hope, et al., 98 F.T.C. 58 (1981) (consent order).

On July 30, 1980, the Commission issued a complaint alleging that all five physicians in Brownfield, Texas had conspired to boycott the local hospital to prevent a new physician specializing in obstetrics and gynecology who was recruited by the hospital from coming to Brownfield to work for the hospital under a contract. The physicians allegedly threatened to refuse to provide emergency room coverage or to fulfill certain administrative obligations to the hospital. The complaint also alleged that the physicians conspired to boycott physicians recruited by the hospital, by refusing to work with, refer to, or accept referrals from those physicians, because they disagreed with the terms of the financial arrangements the hospital planned to make with recruited physicians. At the time the respondents took the alleged actions, they were the only physicians in active medical practice in Brownfield, and the nearest hospital where other emergency care or obstetrical care by a specialist was available was 35 miles from Brownfield.

On August 5, 1981, the Commission approved a consent order settling the complaint. The respondent physicians agreed not to take any concerted action to interfere with a hospital's efforts to recruit, or enter into a contractual arrangement with any physician. The order does not prohibit the physicians from commenting on bona fide quality of care considerations such as a physician's qualifications or competency.

Senator SPECTER. We are very pleased to have with us today Charles F. Rule, Deputy Assistant Attorney General, the Antitrust Division. We welcome you here, Mr. Rule. Your full statement will be made a part of the record.

We note that when you were appointed earlier this year, you became the youngest Deputy Assistant Attorney General in the history of the Antitrust Division. I note that prior to your appointment you served as Special Assistant to the Assistant Attorney General in charge of the Division.

Thank you very much for joining us, and we look forward to your views.

In accordance with our committee practice, we would appreciate it if you would summarize your statement, leaving the maximum amount of time for questions and answers.

STATEMENT OF CHARLES F. RULE, DEPUTY ASSISTANT ATTORNEY GENERAL, ANTITRUST DIVISION, DEPARTMENT OF JUSTICE

Mr. RULE. Thank you, Senator, and I will do that.

I want to first congratulate you and the Senate for considering this very important problem, the problem of spiralling health costs. I think it's almost a national emergency, some could say.

Health care expenditures account for over 10 percent of the GNP. Over the last 13 years, health care costs have nearly tripled, far outstripping the rise in the Consumer Price Index.

I think that to look at the problem, you have to look at the background here. It's only recently, as Mr. Muris has pointed out, that competition has begun to emerge in the health care industry as an important force. Prior to that, restricted entry, little price competition, and regulation tended to stifle market forces.

The lack of competition basically exacerbated some of the natural problems that exist in this industry. Individual consumers, as you pointed out, Senator, when bargaining in the marketplace for health services, frequently are at an informational disadvantage. It is difficult for them to determine whether or not a given service or procedure is needed, whether or not it is adequate, and whether or not the price charged is reasonable.

Insurance, to some extent, has eliminated this problem by having a third-party payer aggregate a number of purchasers, increase their bargaining power, increase their access to information and, therefore, eliminate many of these informational disadvantages that normally would face the consumer.

However, as you have also pointed out, third-party payment insurance also creates some problems. It tends to make individual consumers, those people who go out and actually demand the services, insensitive to price. And also the historic use of retroactive cost-based reimbursement has reduced the providers' incentives to keep costs down.

Recent changes in the industry, however, have induced more competition and, as a result, free-market incentives have led to solutions of some of these old problems and, in turn, have helped to begin the process of containing health care costs.

Increased competition has taken place in the provision of health care services. We have seen the rise of innovative, preventive health care plans, such as HMO's, and new alternative providers of health care services, such as free-standing clinics, and, as well, an increased capacity in the medical profession itself.

We have also seen increased variety and competition among third-party payors, and insurers. We have seen the rise of preferred provider organizations, competition among them, the rise of HMO's, selective contracting by insurance companies—all of which has led to increased competition.

In addition, as a result of this increased competition, a number of innovations have arisen that have tended to increase consumer price sensitivity and provider cost sensitivity. I am speaking now of such ideas as coinsurance and deductibles, which have increased consumer sensitivity to relative prices for services. Also we have seen prospective payment of fees sensitive to costs, a la Medicare, that have increased the cost sensitivity of providers.

This increased competition, I think, will over time be a significant factor, perhaps the most important factor that we can have, in keeping costs down. But it is important to remember that this trend is in its infancy and it should be encouraged and not discouraged.

The antitrust laws, again as Mr. Muris has pointed out, have provided an important stimulus for this trend. They provide the means for thwarting efforts to nip this trend in the bud. There have been a number of efforts, both by the FTC and ourselves to ensure competition. For example, the Department of Justice, has challenged mergers in the health care field, mergers among hospitals and nursing care facilities that threatened to reduce competition and raise the cost of services both to insurers and to ultimate consumers.

Senator SPECTER. Has there been any action by your Department, Mr. Rule, against insurance companies?

Mr. RULE. There have been none at this point. We have tended to focus, up to this point, on providers. There have been several cases that have been brought by private parties against insurers, however.

But at this point——

Senator SPECTER. What kind of cases have those been?

Mr. RULE. Well, for example, there are a number—one of the cases that frequently is cited is the *Kartell* case that arose in Massachusetts that involved some cost containment efforts by providers there. There was also a case in Sausalito, CA, that challenged some cost containment efforts.

Senator SPECTER. By providers you say?

Mr. RULE. No, these were cost containment efforts by insurers—Blue Cross in the *Kartell* case.

Senator SPECTER. What had Blue Cross done there?

Mr. RULE. Well, Blue Cross, for example, in the *Kartell* case had done a number of things. A great deal of the activity was deemed to be exempt from the antitrust laws under two doctrines—the McCarran-Ferguson Act, or the State action doctrine. That was a district court case. There was one particular aspect of their cost

containment efforts, which was a ban on balance billing; that is, it prohibited—

Senator SPECTER. A ban on balance billing?

Mr. RULE. Ban on balance billing. It prohibited providers from charging insureds an increment over what the provider would be reimbursed by the insurance company. So, in other words, the provider was limited to taking what the insurance company offered.

The court judged the prohibition under the Rule of Reason, ultimately finding that it was unreasonable.

I think that case, though, can be explained by some of the unique aspects of Massachusetts law, and by the fact that Blue Cross/Blue Shield had a lot of market power there. But I think that the important thing in that case is that the court viewed the ban under the rule of reason and considered whether or not the restraint under the circumstances was reasonable, the same approach as was taken in the *California* case.

And I think, again as Mr. Muris has pointed out, that gives insurance companies adequate flexibility to engage in the sort of activities that will contain costs, that will benefit competition, and that, in turn, will benefit consumers. At the same time, it will provide a very flexible and adequate safeguard to prevent the sorts of activities that in fact harm consumers and that none of us would want to see continued in the marketplace.

And, again, I should say that although we have not focused on insurance, if there were a problem there, we would pay attention to it. But one of the benefits of the current mix of private and public enforcement is that it enables us to be selective and to go after those specific areas in which we see problems instead of having to try to spread our resources very thin and cover all the potential areas where there might possibly be problems.

We, of course, laud the efforts of private attorneys general—they have been an important part of the antitrust laws in this as well as other areas.

In addition to the challenges of mergers in the health care field, the Department has also challenged agreements by providers to drive up prices to third-party payors, and to deny third-party payors the benefits of discounts that they might otherwise negotiate. There also have been efforts by providers to exclude alternative providers from the market.

We think that S. 2051 would threaten this trend and would threaten the ability of the antitrust laws, and the antitrust law enforcement agencies to insure competition and to prevent competitive abuses.

Section 4 of the bill arguably would exempt from the antitrust laws virtually every significant activity of health insurers. Again, there is not a view that everything that is listed there imaginable under section 4 is a problem; in fact, much of it is beneficial. We have given, for example, favorable business review letters on information exchanges in a number of cases.

Senator SPECTER. Do you think that if the insurers came to you with a proposal under section 4, section C as well, that it would conceivably get approval by the Antitrust Division?

Mr. RULE. Is it conceivable that it would get—

Senator SPECTER. Well, I've given you a broad term.

Mr. RULE. It is conceivable that there is going to—I mean, it is not only conceivable, I can pretty much guarantee it: There are going to be a number of activities that fit within that definition that do not violate the antitrust laws.

Senator SPECTER. So that if insurers came to the Antitrust Division and gave you a plan for acquiring, under A, and collecting, under B, and negotiating, under C, that there would be some latitude that you think would be appropriate without being anticompetitive or violative of the antitrust laws?

Mr. RULE. I certainly think that's true; that is reflected in the rule-of-reason analysis and it's reflected in a number of business review letters that we have already given.

Senator SPECTER. And how long does it take to get such an advisory opinion?

Mr. RULE. It really depends; we have given them in as little as several weeks, when there is an emergency, but generally I would say that 3 to 6 months is probably our average. It really depends on the circumstances. We obviously want to make sure that we know all the facts before we are giving a statement of our intention of that sort.

[Prepared statement follows:]



Department of Justice

STATEMENT

OF

CHARLES F. RULE
DEPUTY ASSISTANT ATTORNEY GENERAL
ANTITRUST DIVISION

BEFORE

THE

COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

CONCERNING

THE "HEALTH CARE COST CONTAINMENT ACT OF 1983" - S. 2051

ON

JUNE 26, 1984

Mr. Chairman and members of the Committee:

I welcome this opportunity to meet with you today to discuss S. 2051--the "Health Care Cost Containment Act of 1983."

S. 2051 would exempt from the operation of the federal antitrust laws a wide range of activities of health insurers and other third-party payors of health care costs. In introducing this bill, Senator Specter indicated that it was a starting point in discussing the need for such proposals to combat a national crisis caused by the disappearance of affordable health care in this country. The Justice Department shares the view that the problem of spiraling health costs is one of the most important problems facing the American public today. However, we believe the solution to this problem rests on greater, not less, reliance on competitive market forces and thus oppose the establishment of new antitrust immunities in the health care area.

Health care is a universal need. In 1982, it accounted for \$322.4 billion, or 10.5% of the Gross National Product. 1/ The consumer price index for medical care has been rising at an astounding rate, nearly tripling between 1970 and 1983. 2/ This is substantially faster than the rate of increase of the overall consumer price index during the same period. 3/

1/ Statistical Abstract of the United States (1984) Table No. 144.

2/ Statistical Abstract of the United States (1984) Table No. 811.

3/ Id.

There are several, somewhat peculiar aspects of the health care market that are in large part responsible for these disturbing trends. Because individuals in need of health care services often do not have adequate information about the comparative value of the price/quality options they face, the market for health care services is characterized by high transaction costs. A patient, for example, may be unable easily to determine whether the prices he or she is charged are too high or the procedures being performed are unnecessary.

Private health insurance has in part offset some of these transaction-costs problems. Health care insurance has been very important in ensuring that the American public has adequate access to medical care. By pooling his or her health care risks with those of others, the insured is able to obtain medical care, even when struck with a malady or injury the cost of which otherwise would be prohibitive. The third party payment of health care services provides, moreover, a means of eliminating many of the transaction-costs problems associated with the procurement of health care services by individual consumers. Because the insurance company acts as a purchasing agent for a larger number of individuals and thus procures a large amount of medical services, it is often at less of an informational disadvantage in the market than the individual consumer.

Because insurance involves the third-party payment of fees, it also creates problems that may cause the overall cost of

health care to increase. The individual with health care insurance generally does not pay the cost of health care and so may be insensitive to whether a price is reasonable or a service necessary. For the consumer with comprehensive health care insurance, whose insurance company pays the entire cost of health care, money literally is no object.

These problems are exacerbated where the third-party payor for health care services pays providers on the basis of retroactive cost-based reimbursement. This method of payment provides little incentive for cost savings by providers. As a result, because health care providers largely receive their fees from third-party payors, they have less incentive to keep health care costs down than other sectors of the economy. This may be especially true because of the risk that a decision not to perform a particular medical procedure may subsequently be the basis of a malpractice suit.

Although these problems are a concern, competition, combined with private initiatives, have begun to provide solutions. The genius of our free market system is its ability to overcome obstacles to its smooth functioning and to provide the incentives for keeping costs down at the same time that quality and variety of choice are increased. In the health care market, there are a number of examples of beneficial competition at work. The entry of such new players as alternative health care providers, free standing care units, and preventive care organizations (e.g., HMOs) has increased

competition in the provision of health care. Greater use by insurance companies of co-insurance and deductibles in health care insurance policies has increased consumer sensitivity to the costs of health care and should help infuse price competition into the system. The emergence of new forms of health care financing through HMOs, PPOs and the other means of selective contracting with providers promises greatly to enhance competition in health care markets. And the recent introduction of prospective payment in the Medicare reimbursement system places incentives upon hospitals to provide services at lower cost. We have only just begun to witness the benefits of increased competition in this industry.

The Department of Justice has devoted a substantial amount of its enforcement resources to maintaining and promoting competition in the health care field. In particular, we have taken steps to protect and promote a high level of competition among providers of health care services. The Department has challenged a number of acquisitions of nursing homes and hospitals that would have substantially lessened competition in the relevant markets. 4/ We have challenged agreements among providers in Montana 5/ and South Carolina 6/ to engage in

4/ See, e.g., United States v. National Medical Enterprises, Inc., Civil Action No. F-83-481-EDP (E.D. Calif.; filed Oct. 31, 1983); United States v. Beverly Enterprises, Inc., Civil Action No. 84-70-1-MAC (M.D. Ga.; filed January 18, 1984) (decree entered).

5/ United States v. Montana Nursing Home Assn., Civil Action No. CV-80-92-H (D. Mont.; filed June 13, 1980).

6/ United States v. South Carolina Health Care Assn., Civil Action No. 79-172-9 (D.S.C.; filed August 27, 1979).

collective activities aimed at driving up the prices paid by a third-party payor--in those cases the State Medicaid agency. We recently challenged an agreement among hospitals and their trade association in North Dakota 7/ that we contend inhibited the efforts of the Indian Health Service to obtain discounts from hospitals. We have also instituted legal proceedings to enjoin providers in Florida from collectively acting to preclude the development of HMOs in their county. 8/ We have several other investigations pending involving possible attempts to evade the rigors of competition in health care through collusive activity.

In short, the Department of Justice is convinced that competition can and should play an important role in the containment of health care costs. By preserving and promoting competition in the health-care industry, the antitrust laws are essential to the national effort to contain health-care costs. We thus see no need for the broad antitrust exemption proposed in S. 2051, nor are we convinced that it would promote consumer welfare.

7/ United States v. North Dakota Hospital Assn., Civil Action No. 82-131 (D.N.D.; filed August 25, 1983).

8/ United States v. Halifax Hospital Medical Center, Civil Action No. 78-554-Orl.-Civ-Y (M.D. Fla.; filed Nov. 27, 1978).

Section 4 of S. 2051 creates an exemption from the antitrust laws for three types of activities undertaken individually or jointly by insurers or "other persons engaged in making payments with respect to charges for health care services." 9/ The first exempted activity includes the collection, analysis, publication and use of information on the quality, cost or utilization of health care services. The second covers collecting and distributing insurance claims for health care services. The third exemption covers negotiating, entering into, or acting upon agreements with health care providers with respect to the utilization of health care services or the levels of charges or reimbursement for health care services. Each of these exemptions is very broadly-worded. Conceivably, virtually every significant activity engaged in by health insurers or other third-party payors could be exempted from the operation of the antitrust laws by S. 2051.

Section 5 of the bill allows the Attorney General to investigate activities undertaken by insurers, but only to determine (1) whether they are subject to the Act; (2) whether they have had or will have the effect of increasing the cost of health care; and (3) whether they "unduly" restrict

9/ Although the language of the bill is unclear, we believe that this term likely was intended to cover only "third party payors" and would not include individual consumers of health care services.

competition. If the Attorney General determines that a given activity has a prohibited effect, he is required to issue a written notice and seek an injunction 60 days thereafter if the activity is not voluntarily discontinued.

Our review of S. 2051 has been complicated by a basic ambiguity in the bill. There appear to be two possible interpretations of the operative provisions of the bill (i.e., sections 4 and 5). One interpretation is that the standards to be applied by the Attorney General in assessing the competitive impact of activities covered by the bill are the same as existing antitrust standards. If this interpretation is correct, then the principal effect of this bill, if passed, would be to preclude criminal and private antitrust actions, but to leave intact the substantive standards for civil enforcement actions by the Department.

A second possible interpretation is that the bill would not only eliminate private enforcement efforts and criminal actions but would also alter the substantive legal standards in this area. Section 5 of the bill requires the Attorney General to decide whether conduct covered by the Act "unduly" restricts competition or has the effect of increasing costs. Section 1 of the Sherman Act proscribes conduct that imposes an "unreasonable" restraint on trade. The bill's choice of the word "undue" instead of "unreasonable", as well as its focus on costs, could be interpreted to immunize some conduct that would violate existing antitrust standards. Under this

interpretation, the bill would leave to the Attorney General the task of developing new substantive standards, perhaps balancing competitive goals with other factors relating to health care costs.

The Department would be strongly opposed to the passage of legislation that was intended to change the current substantive antitrust standard as applied to the agreements listed in section 4. The antitrust laws rest on the premise that a competitive market system is the best means of efficiently allocating society's resources. On its face, S. 2051 might protect not only activities listed in section 4 that have limited potential for adverse consequences, but also those that are blatantly anticompetitive, such as agreements not to deal with any provider that associates with a competing health insurer or new health plan or payment system.

From the standpoint of maximizing benefits to consumers, one of the most encouraging developments in the health care field has been the growth of health maintenance organizations (HMOs), preferred provider organizations (PPOs), and other new or alternative forms of health care delivery and financing. These innovations are already applying downward pressure on health-care costs, while maintaining the quality of health care and giving consumers a wide variety of choices. In many states, third-party payors have begun to compete vigorously in developing and promoting such innovations. This bill, however, could exempt from the antitrust laws agreements among insurers

as to the types of PPOs they might favor or as to which independently operated PPOs they would deal with and on what terms. It could also eliminate sub rosa the boycott exception to the antitrust immunity provision in the McCarran Ferguson Act. Ironically, then, the effect of the bill could be to restrain competition and to curtail those activities that hold the greatest promise of containing health-care costs.

Of course, section 5 of S. 2051 does contain a safeguard (albeit an ambiguous one) against unreasonably anticompetitive activities and agreements. But this safeguard is essentially new federal regulation of the practices of insurers and other third-party payors throughout the entire country under very general and vague standards. In essence, section 5 would place the Attorney General in the quasi-regulatory role of determining, in the first instance, whether the activities of insurers (1) are subject to the Act; (2) have had or will have the effect of increasing the cost of health care services; and (3) have had or will have the effect of "unduly restricting competition in the delivery or financing of health care services." Under the bill, the Attorney General would then issue a notice of any adverse determinations on those issues and would indicate what steps were necessary to bring the activities into compliance.

Under any interpretation, section 5 will obligate the Attorney General to make extensive and complex findings regarding the effect of third-party payors' activities on

health care costs and on competition. The possibility for error, especially as to conclusions about effects on cost, would be significant. Moreover, these problems are exacerbated by the fact that S. 2051 does not provide clear standards to govern the Department's inquiry and by the necessity of coordinating the process with state regulation of health care. In addition, because there would be no private cause of action, the Department would be compelled to investigate many more agreements than are currently investigated. The cost of such a regulatory scheme--both to the federal government and to the health care industry--would be substantial. However, the benefits are likely to be slight, if they exist at all. In sum, the proposed regulatory scheme would be far less effective than competition in containing costs. And the current antitrust standards are the best, most flexible means of ensuring the competitive performance of health care markets.

As against these significant problems created by replacing the current antitrust standards with a new regulatory scheme, we know of no problems that the antitrust laws currently are causing in this area and that require such a costly solution. We do not believe the antitrust laws pose any serious threat to agreements and activities that increase efficiency in the health care industry. The bill would cover, for example, agreements among insurers to collect and analyze data, which can be useful in cost containment. The Department recognizes that in most cases the exchange of information can improve

rather than hinder the functioning of competitive markets and should not be condemned. Such exchanges would not violate the antitrust laws unless carried on with the purpose or effect of fixing prices or facilitating boycotts. Indeed, the Antitrust Division has sent business review letters to the Maryland Health Care Coalition and the Southwest Michigan Health Systems Agency advising that we would not challenge proposed information exchanges. We know of no circumstances in which beneficial information exchanges in the health care industry have been condemned under the antitrust laws.

Similarly, the other activities enumerated in section 4 would not be condemned under the antitrust laws unless they were unreasonable. However, when the activities described in section 4 are anticompetitive and so harm the interests of consumers, the antitrust laws do proscribe their use. The Department believes that the current antitrust standards should be permitted to continue to proscribe those activities where they injure competition.

Even if Congress were to make clear that in passing this bill it intended to leave substantive antitrust standards intact and merely to eliminate criminal antitrust enforcement and private actions, the Department would still oppose its enactment. The need for such a bill has not been demonstrated. The antitrust laws are designed to enhance consumer welfare, and the current balance of public and private enforcement remedies was a product of careful congressional

deliberation. The Department could not endorse a blanket exemption from private and criminal enforcement actions for the health insurance industry in the absence of a showing that the burden imposed on health care providers by such actions (or the possibility of such actions) is unusually severe and that the threat or institution of such actions is causing a loss in consumer welfare that cannot otherwise be avoided. The Department has seen no evidence that this is the case.

Insofar as criminal actions are concerned, the decision to proceed criminally is never made lightly. The Department is careful not to abuse its power to indict antitrust defendants. To our knowledge, no one has suggested that the possibility of criminal action is chilling legitimate cost containment efforts in the health care industry. If any party in the health care industry fears that certain activities in which it wishes to engage may expose it to criminal liability, it can determine the Department's enforcement intentions under the business review procedure.

Private remedies generally serve as an important adjunct to government antitrust enforcement activities. The Department has on rare occasions supported carefully tailored limitations on private remedies, but only in the face of demonstrated need. We have not seen such a need demonstrated in the health care area.

To summarize, Mr. Chairman, the Department has a strong interest in helping to find ways to contain the rise of health

care costs. This is an important subject and one worthy of attention at both the state and federal levels. While there is probably no one solution to this problem, we feel that encouraging competition should be an important ingredient of any remedy. Competition can promote cost containment, and it has the advantage of protecting quality and promoting variety to the benefit of the American public. Recent developments in this industry suggest that competitive forces are beginning to come into play. We feel that competition should be fostered rather than deterred, and thus we do not support a change in the antitrust laws premised on the idea that regulation would be superior to competition.

Mr. Chairman, that concludes my prepared remarks. I would, of course, be happy to respond to any questions that you or other members of the Committee may have.

Senator SPECTER. What I would like to do at this time is to turn to Mr. Reese—and I would like you gentlemen to stay, if you would. And we will hear from Mr. Reese and his colleagues, and then perhaps have an exchange—we will focus on matters that we might have some interchange on.

We welcome you here, Mr. Reese. We note your curriculum vitae, that you are president and chairman of the board of Provident American Corp., Provident Indemnity Life Insurance Co., and Montgomery Management Corp., and that you are appearing here today also representing the Heath Insurance Association of America, a trade association of some 300 insurers, which together write over 80 percent of the health insurance sold by insurance companies in the United States.

And in addition to the very prestigious professional and civic activities which you have undertaken and your 32 years of experience in the insurance sales and sales management, it also might be noted that you have had a distinguished record in public service in the Office of Special Investigation of the U.S. Air Force in 1951, 1952, and 1953 when you served as a special agent along with Arlen Specter in the customhouse in Philadelphia, PA. It was where I first got to know Mr. Reese, a chapter from our lives in the dim dark past—we were in public service together.

So we welcome you here, Mr. Reese.

STATEMENT OF JOSEPH H. REESE, JR., CHAIRMAN OF THE BOARD AND PRESIDENT OF PROVIDENT INDEMNITY LIFE INSURANCE CO., NORRISTOWN, PA, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. REESE. Thank you, Mr. Chairman, for those kind words and for the reflection on history.

Senator SPECTER. And if you would introduce your colleagues, we would appreciate that.

Mr. REESE. I shall indeed. I am accompanied by John R. Hurley, assistant general counsel of the Health Insurance Association of America, and James A. Dorsch, Washington counsel of the HIAA.

I will summarize my remarks and request that the full statement be accepted for the record.

Senator SPECTER. Your full statement, without objection, will be made a part of the record, Mr. Reese.

Mr. REESE. We firmly support the enactment of S. 2051. This bill grants to the insurance industry a very limited exemption from the application of antitrust laws so that insurers may collect and use health care data on a joint basis to control health care costs, and to jointly negotiate with health care providers for cost-effective, quality health care for their insureds. The bill also provides for surveillance of these activities by the Attorney General.

The purpose of my statement is twofold. I would like, first, to describe to you the problem of cost and competition which confronts the entire industry; then I would like to speak on behalf of our own company and also many other smaller life and health insurers in the country who are directly affected by the severely escalating medical provider costs in our country and by cost shifting that has

resulted from underpayment for health care by the Federal Government.

The high cost of health care is a national problem which to date has defied solution. From December 1982 to December 1983, as you noted previously, the national inflation rate has averaged 3.8 percent, but the hospital room-and-board component of the Consumer Price Index rose 9.3 percent with significantly higher increases in the larger population centers.

Health care expenditures now represent 10.4 percent of the GNP, or \$362 billion. The expansion of the system, for better or worse, continues unchecked by either regulation or by market forces.

The incredible advances in medical technology have contributed greatly to our society's wellbeing. But the influence of new devices, tests, and drugs has pushed the cost of health care upward in very dramatic fashion.

Another problem which drives up the cost of care is the inefficient and anticompetitive payment systems used to fund hospital care. It is not hard to see that a system where the hospital spends, and then is reimbursed without any true accountability to anyone, provides no incentive for the hospital to save money or to operate efficiently.

The noninvolvement of the consumer in the decisions made in providing health care is also a factor involved in the escalation of health costs. Out of fear of sickness, lack of knowledge, trust in physicians, or in most cases "the insurance company will pay for it," consumers have little incentive to seek out cost-effective treatments.

The Federal Government, and some Blue Cross plans, because of their structure and status, possess concentrated market power in dealing with hospitals. They can protect their positions through issuing regulations or by hard bargaining. For the vast majority of the country, however, neither the insurance companies nor the employers have sufficient local volume to negotiate effectively.

There are over 1,000 companies selling health insurance, many on a nationwide basis. The market is extremely dispersed. The reason lies in the highly competitive structure of the industry.

In 1983, the largest health insurer underwrote, though, only 4.3 percent of the health insurance business, and the business of the top 20 companies totaled less than 26 percent. Since these companies operate in 50 States and may have insured patients in any of 6,000 hospitals, their individual buying influence in any particular hospital is almost nonexistent.

Some observers question why insurers do not act jointly to influence provider behavior on costs and quality of care. The answer lies in the concern of the insurance industry that such joint action would subject it to governmental and private actions charging violation of Federal and State antitrust laws.

If insurers are allowed to use their aggregate market power on a joint basis, they can become the kind of bargaining agent for their customers that is needed to place appropriate market forces into play in the health care delivery system. Consumers could also use this data, put together by our companies, to play a more effective role for themselves.

Without such joint action, hospitals and doctors can continue to price their services and use them without any limitation.

The antitrust laws were formulated to promote and assure the American public of the benefits of competition. In this case, the application of those laws to insurers is stifling efforts to promote competition in a field where such efforts are drastically needed.

In this case, a limited exemption to the antitrust laws is necessary to carry out the intent of those very laws.

Now I would like to show you how this cost problem and this competitive dilemma has affected and does affect my own company.

Provident Indemnity was founded in 1895, has approximately \$21.5 million of assets, and annual revenues of about \$20 million. Our company operates in 14 States and our principal source of business is providing health insurance coverage for small employers.

Currently we have in excess of 2,500 small businesses who rely on us for their health insurance coverage. We are one of relatively few insurance companies left in the United States who are still operating in the small group health field, with most having dropped out because of extensive operating losses in their health insurance lines.

As a matter of fact, many insurance companies have been driven completely out of the health business as a result of major losses in this part of their operations, including such substantial companies as the Penn Mutual Life Insurance Co. of Philadelphia, where I spent the beginning years of my own career.

To illustrate the impact of escalating health costs, I would like to furnish you with some figures concerning the operations of my own company. In 1979, Provident Indemnity had health insurance premiums of approximately \$8.6 million, which produced an actual profit of \$534,000 from the health business.

In 1980, health premiums increased 14.7 percent, to approximately \$10 million, while health claims went up 37.5 percent, resulting in an operational loss from the health business of \$634,000.

In 1981, health revenues increased 23.4 percent, but claims increased 32.3 percent, bringing about a loss from the health business of \$1,464,000.

In January 1982, a new management team, including myself, became involved with the company in an effort to help resolve these problems. During that year, revenues on health insurance went up 20.8 percent, to \$14.8 million, but claims increased 26.1 percent, resulting in an operational loss from the health insurance business of \$2,613,000.

During the 3-year period, from 1979 to 1982, health insurance revenues increased 71 percent while incurred claims went up 120 percent.

Senator SPECTER. How long can you stay in the business?

Mr. REESE. I will address that. We couldn't stay in business much longer. As a matter of fact, the total losses during those 3 years came to \$4,712,625 from health business, or an amount equivalent to approximately 2½ times our company's net worth as of December 31, 1981.

Senator SPECTER. What's happened since that time? Your statistics go into 1982, 1983?

Mr. REESE. In 1983, I am pleased to report, we made a slight operational profit in the health insurance business. However, Senator, we are very much concerned, we remain alert—we are a small company with limited reserves, and we recognize the great risk that we are taking by being a health insurer in today's environment.

We are also concerned, quite frankly, with the consumers' ability to continue to sustain very large annual increases in health premiums.

You asked a question, how we survived. We have survived that period by substantial premium increases, by drastic termination of coverages, by the total elimination of poorer risk clients, by very high selectivity of new insureds, as well as very substantial new investor capital.

The factors that have hurt our company during these troubled years are many, but mostly that we have been faced with rapidly escalating health costs, both medical and surgical, at a rate three and four times the rate of general inflation.

It would have been difficult for us to have raised our insurance rates as fast as medical providers raised theirs without a major loss of business occurring.

The position of the smaller health insurance companies has been quite severe, both because of the competitive environment and our inability to fall back on substantial dollars of reserves which do exist with some of the larger carriers.

In closing, we feel that the passage of Senate bill 2051, while not a panacea to the problem, is a significant step toward cost containment, enabling insurers to use our combined market power that would enable us to take an aggressive bargaining position for the benefit of all consumers.

S. 2051 would enable the insurance industry to compile and use joint health care data, to give customers more information about charges, length of stay, testing procedures and the like, that would result in a consumer being more educated, more aware, and thus more likely to do something about health care costs.

S. 2051 is the embodiment of competition. It calls for no new regulation; its purpose is to enhance real competition in the delivery and financing of health care. If the national goal is to reduce health care costs and if the Congress acts favorably on S. 2051, the health insurance industry will gladly do its part. We simply ask for the tools with which to work.

Thank you.

Senator SPECTER. Thank you very much, Mr. Reese.

[Prepared statement follows:]

STATEMENT
OF THE
HEALTH INSURANCE ASSOCIATION OF AMERICA

PRESENTED BY
JOSEPH H. REESE, JR., CLU

I am Joseph H. Reese, Jr. Chairman of the Board and President of Provident Indemnity Life Insurance Company of Norristown, Pennsylvania. Today I also represent the Health Insurance Association of America. HIAA is the national trade association of the health industry. It consists of over 300 insurers which together write over 80% of the health insurance sold by insurance companies in the United States.

I am accompanied by John R. Hurley, Assistant General Counsel, and James A. Dorsch, Washington Counsel, of the HIAA.

We firmly support the enactment of S. 2051. This bill grants to the insurance industry a very limited exemption from the application of antitrust laws so that insurers may collect and use health care data on a joint basis to control health care costs, and to jointly negotiate with health care providers for cost-effective, quality health care for their insureds. The bill also provides for surveillance of these activities by the Attorney General.

The purpose of the Act is simply to allow insurers to better use their market influence to help hold down the calamitous rise in the cost of getting well. The Act also will help to provide consumers with more and better information so that they can become a moderating force on health care costs.

The purpose of my statement is twofold. I would first like to describe to you the problem of cost and competition which confronts the entire industry. Then I would like to speak on behalf of our own company and also many other smaller life and

health insurance companies in this country, who are directly affected by the severely escalating medical provider costs in our country, and by the cost shifting that has resulted from underpayment for health care by other payors, including the federal government.

The Problem

The high cost of health care is a national problem which to date has defied solutions. From December 1982 to December 1983, the national inflation rate averaged 3.8%, but the hospital room and board component of the consumer price index rose 9.3% with significantly higher increases in the larger population centers. Health care expenditures now represent 10.4% of the GNP, or \$362 billion. The expansion of the system for better or worse, continues unchecked by regulation or market forces. In the states of Massachusetts and New York in 1983, over \$2-1/2 billion in new hospital-related construction was planned, and would have gone forward except for legislative and executive moratoria imposed by those states. In Pennsylvania, similar approved construction totaled \$2.743 billion for 1979-1982 and no effective mechanism, public or private, exists to question the need for such expansion or to provide competitive checks and balances.

Every American consumer is bearing the burden of health care inflation. We pay for it in increased taxes to pay for Medicare and Medicaid, which cost taxpayers over \$70 billion in 1981. We pay for it through increased health insurance premiums, which rise in response to the higher cost of care. Annual premium increases of 30% and more are not the exception today, but the rule. We pay for it through the increased costs of goods and services passed through by employers who bear the impact of health care inflation on employee benefit plans. If nothing is done to control these increases, the nation will not be able to afford the costs of getting healthy. When a semiprivate room in Philadelphia reaches today's average cost of almost \$300 a day and has increased in cost 160% since 1976, it is clear that many people will soon be

forced to make hard choices -- not about the level of care or of health insurance protection they can afford, but whether they can afford health care protection at all.

The Causes

The incredible advances in medical technology have contributed greatly to our society's well-being. But the influence of new devices, tests and drugs has pushed the cost of health care upward in dramatic fashion. Professor Carl Schramm of Johns Hopkins has made the following observations:

The rapid profusion of sophisticated equipment for diagnostic testing is well-documented, and the meteoric increase in the routine administration of recently developed tests is known to be one of the most important causes in inflation of hospital costs and total health expenditures...

New technology in health care nearly always creates a demand for new, more highly-skilled technicians...

...the net result is a higher total labor bill... To the extent that new technology continues to be developed and proliferated and to the extent that physician's incomes increase in proportion to the amount of testing ordered, the phenomenon of new technology and new capital equipment being linked with higher unit prices will remain a distinctive characteristic of the health care market.*

*Schramm, "A State-Based Approach to Hospital Cost Containment," 18 Harvard J. Legis 603 at 611 (1981).

A leading problem which drives up the cost of care is the inefficient and anticompetitive payment systems used to fund hospital care. It is not hard to see that a system where the hospital spends, and then is reimbursed without any true accountability to anyone, provides for no incentive for the hospital to save money or to operate efficiently. On the contrary, if a hospital wants more revenue, all it has to do is spend more money. Recent amendments putting the Medicare Program** on a prospective pricing system will admittedly hold down Medicare outlays, but hospitals can simply raise charges to private patients. If the change to a prospective system provides the right incentives to control health care expenses, and we agree that it does, changes are equally needed by those who are not eligible for Medicare.

Another factor involved in the escalation of health costs is the non-involvement of the consumer in the decisions made in providing health care. Out of fear of sickness, lack of knowledge, esteem and trust for physicians, and because in most cases "the insurance company will pay for it," consumers have little incentive to seek out cost-effective treatments. Consumers do not have any idea what charges are being made for care, why they are in one hospital rather than another, or why any particular course of treatment, expensive or not, is necessary. Physicians and hospitals understand all too well the patients insulation from the impact of the cost of care. They have no incentive to practice cost effective medicine. Thus, as many commentators have noted, "only the third party payor has any immediate incentive to control costs".*

The Federal government, and some Blue Cross plans, because of their structure and status, possess concentrated market power in dealing with hospitals. They can protect their positions through

* Kallstrom, "Health Care Cost Control By Third Party Payors", 1978 Duke L.J., 645 at 648 (1978)

**See e.g. P.L. 98-21, Social Security Amendments of 1983, Sec. 601.

issuing regulations or by hard bargaining. For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate effectively.

There are over 1,000 companies selling health insurance, many on nationwide basis. The market is extremely dispersed. The reason lies in the highly competitive structure of the industry. In 1983, the largest health insurer, Prudential, underwrote only some 4.3% of the health insurance business measured by premium volume. The business of the top ten insurance companies totaled only 18.7% and the top twenty companies totaled less than 25.3%.* Since these companies operate in 50 states and may have insured patients in any of 6,000 hospitals, their individual buying influence in any particular hospital is limited.

Some observers question why insurers do not act jointly to influence provider behavior on costs and quality of care. The answer lies in the legitimate concerns of the insurance industry that such joint action would subject it to governmental and private actions charging violation of federal and state antitrust laws.

The McCarran-Ferguson Act offers no protection for insurer joint action on cost containment. Any joint action which would limit or prevent provider reimbursement, such as denying payment to a hospital which overcharges for care, can be construed to be a boycott and thus outside the jurisdictional protection of McCarran. (See 15 U.S.C. Sec. 1013(b); St. Paul Fire and Marine Ins. Co. v. Barry, 438 U.S. 531 (1978). In any case the McCarran Act does not in and of itself protect insurer involvement with

*Source: National Underwriter, June, 1983. Blue Cross data is not available to the National Underwriter or to HIAA. However, we assume for purposes of general description of the market that Blue Cross plans comprise roughly 50% of the market for private health care coverage.

providers in cost containment activity. (Pireno v. Union Labor Life Ins. Co., et al., -- U.S. --, 102 S. Ct. 3002 (1982)).

The Justice Department has expressed considerable concern about any joint insurer activity involving contact with providers on the questions of cost and quality of care.*

The Federal Trade Commission has similarly made it clear that insurer involvement in cost containment activities, while generally permissible, is subject to close scrutiny.**

Insurers believe that if they are allowed to use their considerable aggregate market power on a joint basis, they can become the kind of bargaining agent for their customers that is needed to place appropriate market forces into play in the health care delivery system. Without such joint action, hospitals and doctors can continue to price their services and use them without any real limitation.

The antitrust laws were formulated to promote and assure the American public of the benefits of competition. In this case, the application of those very laws to insurers is stifling efforts to promote competition in a field where such efforts are drastically needed. In this case, a limited exemption to the antitrust laws is necessary to carry out the intent of those laws.

Now I would like to show you how this cost problem and this competitive dilemma affects my company.

Provident Indemnity Life Insurance Company was founded in 1895, has approximately twenty-one and one-half million dollars of

*See, Business Review Letter on Maryland Health Care Coalition, dated February 19, 1982, from William F. Baxter, Assistant Attorney General, to Patrick Renaud.

**See, Advisory Opinion to Health Care Management Associates dated June 22, 1983.

assets and annual revenues of about twenty million. Our company operates in fourteen states and our principal source of business is providing health insurance coverage for small employers. Currently we have in excess of 2500 small businesses who rely on us for their health insurance coverage. We are one of relatively few insurance companies left in the United States who are still operating in the small group health insurance field, with most having dropped out because of extensive operating losses in their health insurance lines. As a matter of fact, many insurance companies have been driven completely out of the health business as a result of major losses in this part of their operations, including such substantial companies as the Penn Mutual Life Insurance Company of Philadelphia, where I spent the beginning years of my own career.

According to the Life Insurance Management Research Association, there are today some twenty-one hundred and ninety-five legal reserve life insurance companies in our country. A.M. Best ranks our company, as of December 31, 1982 as 624th in terms of insurance in force, and 808th by overall assets based on the companies they rate. We are indeed a small company but it would appear that over 60% of all insurance companies in the United States are smaller than we by any measuring device. Our company is a member of both the American Council Life Insurance and the Health Insurance Association of America, but we sometimes are concerned that the impression created by these organizations to the Congress is that all insurance companies are of substantial size and financial worth. The largest 150 insurance companies represent about 80% of all company assets, but there are also some 2000 additional companies, employing thousands of persons, who are not included among the larger company group. Some companies appear to have the wherewithal to sustain themselves through harder economic times, but many insurance companies have had, and will have, great difficulty with the ongoing problem of escalating health costs, speculative rating

procedures which are suggested by other pending federal legislation, and other factors.

To illustrate the impact of escalating health costs, I would like to furnish to you some figures concerning the operations of our own company. In 1979 Provident Indemnity had health insurance premiums of approximately \$8.6 million, which produced an actual profit of some \$534,000 from the health insurance business. In 1980 health premiums increased 14.7% to approximately \$10 million, while health claims went up 37.5%, resulting in an operational loss from health business of \$634,000. In 1981 health revenues increased 23.4% to \$12.3 millions, but claims increased 32.3%, bringing about a loss from health business of \$1,464,000. In January 1982 a new management team, including myself, became involved with the company in an effort to help resolve the company's problems. During that year revenues on health insurance went up 20.8% to \$14.8 million, but claims increased 26.1%, resulting in an operational loss from health business of \$2,613,522. During the three-year period from 1979 to 1982 health insurance revenues increased 71%, while incurred claims went up 120%. The total losses on health insurance business during those three years amounted to \$4,712,625 or an amount equivalent to approximately two and one-half times the company's net worth as of December 31, 1981. Our basic survival has occurred only through substantial premium increases, drastic terminations of coverages, elimination of poorer-risk clients, tremendously high selectivity of new insureds, as well as significant new investor capital. I am pleased to report that health business has now returned to profitability but because of our company's size we remain alert and deeply concerned as to the great risk we are taking by being a health insurer in today's environment. We are also concerned with the consumer's ability to continue to sustain large annual increases in health insurance premiums.

The factors that have hurt our company during these troubled years are many. The major impact on this company has been

external factors over which our company, as is true of other health insurance companies, has had absolutely no control. We were faced with rapidly escalating health costs, both medical and surgical, at a rate three and four times the rate of general inflation, which in itself has been unbearably high as we all are aware. Our industry was caught almost unaware, was slower than it should have been to react, but in retrospect it would have been difficult to raise our insurance rates as fast as medical providers raised theirs without a major loss of business occurring. The position of the smaller life and health insurance companies has been severe, both because of the competitive environment, and our inability to fall back on substantial dollars of reserves which exist with some of the larger companies.

In closing, we feel that passage of Senate Bill 2051, while not a panacea to the problem, is a significant step towards cost containment. Enabling insurers to use our combined market power would enable us to take an aggressive bargaining position for the benefit of all consumers.

S. 2051 would enable the insurance industry to compile and use joint health care data to give consumers more information about charges, length of stay, testing procedures, and the like, that would result in a consumer being more educated, more aware, and thus more likely to do something about health care costs.

S. 2051 is the embodiment of competition. It calls for no new regulation. Its purpose is to enhance real competition in the delivery and financing of health care. If the national goal is to reduce health care costs, and if the Congress acts favorably on S. 2051, the health insurance industry will gladly do its part. We simply ask for the tools to work with.

Description of Limited Antitrust Exemption

The proposal attached to this explanation allows payors of health care, singly or jointly, to do two things: 1) to collect

and use health care data to evaluate the costs and quality of care rendered by providers, and to provide consumers with information about the costs and quality of care which will help them make rational and informed health care provider choices and to promote competition among providers; and 2) to enter into agreements with providers which will stipulate levels of care and cost for health care consumers so that each consumer's health care dollar will be most efficiently spent, and which will promote competition among providers and payors based upon such agreements.

The bill allows the Attorney General to investigate activities undertaken pursuant to this act and to file suit to stop any activity which is found to be increasing health care costs or is unduly restricting competition. This broad power will act as an effective deterrent to potential abuses of this exemption.

The exemption is designed to protect only those designated activities of payors narrowly related to cost containment and would not apply to price-fixing, customer or territorial allocation, or other violations of the antitrust laws, or to other activities which do not have as their sole and specific purpose the containment of health care costs.

The exemption is designed to override any conflicting state law which would prevent payors from performing the bill's designated activities. It is not intended to supersede state hospital cost control statutes or insurance laws which do not conflict with the bill's purpose, but which may impose additional duties or responsibilities on payors or providers.

Conclusion

The magnitude of the health care cost control problem compels government and private business to take unusual steps to reach solutions. Antitrust exemptions are not suggested lightly. But in order to control costs and to promote competition, this narrow exemption must be implemented. Without it, a strong and active

voice for the consumer and for competition will remain muffled and weak.

SYNOPSIS OF BILL

Section 1. The popular name citation demonstrates the direction in which the legislation want the affected parties to go -- toward cost containment.

Section 2. The findings of Congress are self-explanatory.

Section 3. The definitions of "health care provider" and "insurer" are drawn broadly to assure that all interested parties, including employers, Blue Cross plans, HMO's and others, are allowed to participate equally in cost containment activities with all kinds of health care providers, both in and out of hospitals. Similarly, "health care services" as defined in the Medicare law encompasses inpatient and outpatient services of all types.

Section 4. The exemption applies to all federal antitrust statutes and the FTC Act. The activities listed in subsections a) - c) are narrowly drawn to assure that the exemption is not misused and to focus upon proven and effective methods of payor-provider interaction in cost containment.

Section 5. The Attorney General's power to seek injunctive relief if an activity is counterproductive or unduly anticompetitive is meant to allow for speedy and effective cessation of any abuses of the exemption. It is not believed to be necessary to provide for damages since the elimination of the abuses will be self-correcting.

Section 6. State laws which have been construed to prohibit joint payor cost containment action include state antitrust and little FTC acts and insurance unfair trade practice statutes, among others.

Senator SPECTER. Mr. Muris and Mr. Rule, the centerpiece, as I understand it, as to what Mr. Reese is presenting, representing a very significant part of a very important industry in providing competition in health service, is the concentration of market power which the Federal Government has, as a buyer of health services in the country, and Blue Cross/Blue Shield, with their dominant market position, contrasted with, as Mr. Reese puts it, the inability of insurers of his size or the trade association which he represents to negotiate effectively.

What is a balance of fairness here? Why, in your judgment, does it not make sense to have the limited antitrust exemptions which this bill provides, in the context which Mr. Reese explains?

Mr. MURIS. Well, let me, speaking for the FTC, make clear that we are not happy with the status quo, we are not suggesting that there is not a problem; indeed, we are not suggesting that we are not in a crisis situation.

We think that there are a lot of problems that exist and there are many actions that can be taken. For example, in terms of providers, we filed a case in Chattanooga opposing a hospital merger, the Hospital Corporation of America—and that is the kind of situation we thought would have given providers more power. We thought that was a problem.

There are State restrictions on PPO's which we think, just as the Federal Government removed State restrictions on HMO's, would be appropriate to eliminate.

We think there are a lot of other solutions—a cap on the tax-free fringe benefits that employers contribute to employees would be an encouragement to competition.

If you removed the exemption in the Federal Trade Commission Act that nonprofit insurance companies have, we think that would help us police the market.

But we think we ought to take steps toward more competition, not steps toward less competition.

Senator SPECTER. What is your sense as to what Mr. Reese describes as the inability of insurers of his size to negotiate effectively in a free enterprise context, that in order to have any ability to function within the free enterprise system there has to be some greater concentration of power when you deal with companies of Mr. Reese's size?

Mr. MURIS. Well, I would make a couple of comments on that. First, the statistics on a national basis, in terms of the power of commercial insurers, can be somewhat misleading when you get to a local basis. Insurance markets can be very local, and particularly if you insure a major employer or major employers in an area you can have a more significant share.

But more important than that, this leverage can only exist I think in the absence of a competitive situation in terms of the providers, and I think that has been true in the past; it's still true to a significant extent now. But the solution is not to put the payers in a situation of negotiating one on one with providers, where the consumer could be the loser. The situation is to make the providers compete.

And that is starting to happen. We are seeing the surplus in hospital beds, we are seeing doctors with unfilled appointments, we

are seeing a rise in what Mr. Rule talked about, freestanding emergency centers, the other forms of care, we are seeing a rise in PPO's.

Senator SPECTER. Do you think if the insurers could combine that there would be a likelihood of increased medical costs?

Mr. MURIS. Well, I think the danger in joint negotiation is very high. If you are talking about—

Senator SPECTER. What do you see as the principal problem, the principal difficulty?

Mr. MURIS. Well, there are two ways, in its simplest form, that the insurance companies could make more money. They could, one, lower their costs, or, two, they could raise the prices that they charge to the people to whom they sell insurance policies.

I think—

Senator SPECTER. They are not combining to make arrangements as to what they are going to charge; they are not combining to make agreements as to what their insurance premiums are going to be.

The purpose of the combination is to deal with the providers of health care, and, if they can, through some joint action, because of their smallness, or the justification for it because of their small size, have some economies in the costs that they are paying for the medical services, that would enable them to reduce their costs to the buyers of the insurance.

Mr. MURIS. But the problem that we see is that this joint negotiation is a strong incentive to end up with basically the same package; if indeed all the insurers could get together to negotiate under 2051. And if they come up with the same package, you will have less diversity for consumers and a significant, I think very high, increased incentive over what you have now to charge the same price, because, you know, they will have the same package.

Senator SPECTER. Charge the same price to the people who buy their insurance?

Mr. MURIS. Yes.

Senator SPECTER. Let us turn now to our final witness, whom I would like to join the panel.

Mr. REESE. Mr. Chairman, could I take just one word on that?

Senator SPECTER. Yes, of course, you may.

Mr. REESE. Just in reference to Mr. Muris' comments, his material cites the need for a healthy, vigorous, competitive rivalry among health care insurers, and we are not just talking about the insurance industry as one who is a health care payer; we are talking about the Federal Government, Blue Cross, individuals as well as insurance companies. And our request in our statement here is asking that we just be put on the level playing field with the Federal Government and Blue Cross and be able to be put in the same negotiating—or have the same negotiating ability as the "Blues" and the Federal Government does with providers.

Senator SPECTER. Mr. Reese, do you think you would be on a level playing field with the Federal Government if you had this bill passed?

Mr. REESE. We will never be on a level playing field with the Federal Government.

Senator SPECTER. I wouldn't know how to slope the playing field to make it level for you in that context, or with Blue Cross/Blue Shield. It might not be quite so mountainous, but when you talk about a level playing field, I wonder.

Mr. REESE. When you consider the extent of the cost shifting that is going on today, the Medicare cost shift to the insurance industry is currently \$8.8 billion on hospitalization alone—and I don't know how much additional the insurance industry and private payers are paying because of negotiated contracts by Blue Cross.

But if we were in the position of being able to negotiate the same kind of contracts as Blue Cross, it certainly would help the consumer a great deal.

Senator SPECTER. Mr. Rule, you mentioned the rule of reason, if I might go back to that time-honored phrase.

Does Mr. Reese have any point at all in terms of trying to make the playing field somewhat less mountainous for the companies that he is describing?

Mr. RULE. Well, I am not sure what cases Mr. Reese is referring to or what the problems are that he sees. I think the antitrust laws would recognize any benefits to consumers.

The concern here, I think, goes back to what Mr. Muris said, and that is the concern that this is a very broad bill that arguably will insulate a great deal of activity, not just an effort by small private insurers to get together to increase their bargaining power. The bill may result in less variety, higher prices to consumers, even at the same time that there is a reduction in costs. And while we want to reduce costs, we certainly want to make sure that those cost savings are passed on to consumers.

We also want to make sure, it seems to me, that variety and innovation in the medical profession continues.

I think, at the same time, that we want to realize that we have a trend beginning here, an important trend that is resulting from increased competition. There may be a number of innovations that small insurance companies are only now beginning to discover, that the antitrust laws recognize and won't inhibit—and those should be allowed to form. And firms involved in this area should certainly come in and talk to us and the FTC about the antitrust ramifications of the proposals.

But those procompetitive proposals should be allowed to flower, and we shouldn't nip in the bud competition at this most propitious time when we have the opportunity of seeing competition from natural market forces bring down the price and cost of health care insurance, because in the past there has been a great deal of regulation and a great deal of restricted entry that we are now seeing begin to disappear.

And with a broad piece of legislation such as this, it's hard to say whether or not what Mr. Reese is contemplating would be beneficial and would pass muster under the antitrust laws. But certainly, even if it would, there may be various other types of activity that would be immunized under this bill that none of us would wish to see provided immunity under the antitrust laws. And the provisions in section 5 just simply would not be adequate and would be nowhere near as good as having private attorneys general able to bring suits where competitive abuses arise.

Senator SPECTER. Let us now call on Mr. Noel Kroncke, who is the president and chief executive officer of the Children's Hospital Foundation of Philadelphia, to get another perspective.

We note that you have been in this position since 1983 and that you bring a diversity of background, with a degree from Gettysburg College, a master's in hospital administration from Washington University, experience at Lankanaw [phonetic] Hospital, experience with the Children's Hospital National Medical Center in Washington, DC, and the Decatur Memorial Hospital in Decatur, IL.

And we welcome you here, Mr. Kroncke. We appreciate the statement which you have provided us with. It will be made, without objection, a part of the record in full, and we would appreciate your summarizing your testimony in giving us your view of the impact of this legislation from the point of view of a hospital administrator.

STATEMENT OF NOEL E. KRONCKE, PRESIDENT, CHILDREN'S HOSPITAL, PHILADELPHIA, PA

Mr. KRONCKE. Thank you, Senator. My name is Noel Kroncke, and I am president of the Children's Hospital of Philadelphia, the country's first hospital devoted to sick children. I have spent 24 years in health care, the last 4½ as chief executive officer of Philadelphia's Children's Hospital. Prior to that time I spent almost a decade as administrator of the Children's Hospital National Medical Center here in Washington.

I would like to express my appreciation for the opportunity to appear before the Committee on the Judiciary and air my views on the proposed Health Care Cost Containment Act of 1983. Further, I would like you to know that the board of managers at the Children's Hospital, our medical staff and administration share your growing concern about rising health care costs. However, we have great difficulty in agreeing with trends we see developing in the name of cost containment.

There are 131 children's hospitals in the United States that annually care for 500,000 patients and provide 3.7 million days of inpatient care. These pediatric institutions document more than 4.8 million ambulatory visits annually. Their revenues amount to \$2.1 billion, their expenses \$2.3 billion.

The children's hospitals are substantial contributors to the economy through their purchases and payroll taxes. The total expenses of all children's hospitals comprise about 2 percent of the total expenses of all the hospitals in the United States. This may sound relatively insignificant until you think about the Nation's children, their health and the cost to the taxpayers of the future if we should allow them to grow into chronically ill teenagers and adults who cannot take their places as productive citizens in a vital country. They will be a burden to society.

The work we do is expensive, but it contributes to the health of children around the world. We are a regional referral medical center with patients coming to us last year from 22 States and 11 foreign countries. Hospitals like ours maintain patient care programs that help save other hospitals from duplicating many of our

services, conduct research that affects the health of the Nation and operate teaching programs that supply the country with highly qualified pediatricians and surgical specialists.

There is a major problem. Last year the parents of our patients, most of whom are very young, left us with a \$7.8 million loss in bad debts and charity. Of this amount, \$3.5 million resulted from inadequate Medicaid reimbursement.

When health care costs are criticized, the cost of labor is rarely mentioned. Most people are not aware that 65 cents of every hospital dollar is spent on labor.

Forty-nine percent of our patients are under the age of 2½; they can't eat by themselves, they must be fed, medicated, and monitored. They have 24-hour visiting privileges by parents and a corps of almost 500 dedicated volunteers, but we still need professional help to care for these children. Because they are sicker, the children need up to 68 percent more direct nursing care than do their adult counterparts who are hospitalized. The more help, the greater the expense.

No one ever mentions the extra money it costs to delay payment of our bills because our reimbursement from the Government is frequently late, or because parents don't pay on time, even if their children are private or semiprivate patients. Interest has a way of accumulating when vendors are not paid, another reason for the costs to go up.

It is understandable that private insurers are beginning to suspect they will be called upon more frequently to pay for the losses experienced by some hospitals. They intend to resist the rob-Peter-to-pay-Paul principle that will increase as they reimburse hospitals for the care of their patients.

Health costs are up for a good reason, but I believe that getting a waiver to the Sherman Antitrust Act will not solve the problem. Instead, I would ask the private insurance companies to take a broad step by looking into medical progress and realizing that they will save money by reimbursing for extended care and home care alternative to hospitalization.

I would like to challenge the insurers to work together with us on a pilot project, perhaps with several children's hospitals, to see just how much health care costs could be contained by developing plans that include coverage of extended care facilities, halfway houses, group boarding services, and home care.

Why can't the insurance companies make a special effort on behalf of the children and see what creative thinking will do not only to contain health care costs, but to save dollars in the future because sick youngsters will grow into healthy adults.

Instead of permitting insurance companies to band together in the negative sense to seek an exemption to antitrust laws, why not encourage competition among our insurers so that they can develop attractive plans for people with young families, plans that will save money for businesses offering health care as a benefit to their employees because the policies will include stepdown care, encourage early discharge from hospitals and have a major impact on the health of the Nation and the health of our economy.

Senator SPECTER. Thank you very much, Mr. Kroncke. Do you think that the thrust of Senate bill 2051 would ultimately be anti-competitive?

Mr. KRONCKE. Yes, I think it would be anticompetitive.

Senator SPECTER. You think it would be an appropriate way of allowing some companies to get together to contract for medical services, hospital services?

Do you favor the bill, oppose the bill, where do you stand?

Mr. KRONCKE. I am opposed to the bill. Our problem is—yes, there is cost shifting in hospitals, we know that. But there are many services that we provide that have to be paid for. We had a \$3.5 million loss last year, and that was because of Medicaid in the State of Pennsylvania.

We have got legislation this year which puts Children's Hospital under a DRG system in the State of Pennsylvania.

PRIVATE INSURERS PAY MORE

Senator SPECTER. Are you able in your costs, which are privately insured, to do better than you do with Federal reimbursement?

Mr. KRONCKE. Certainly.

Senator SPECTER. How much better?

Mr. KRONCKE. Well, let's start with Blue Cross. We discount Blue Cross bills about 20 percent, and then the Federal Government, on the outpatient side, we receive \$15 a visit for a cost of \$45.

Senator SPECTER. I'm not following you here. Start with the Government reimbursement.

That's a loser for you?

Mr. KRONCKE. That's a loser.

Senator SPECTER. And Blue Cross/Blue Shield, is that a loser for you?

Mr. KRONCKE. They, through contractual discounts, get a 20-percent discount from our charges.

Senator SPECTER. All right, it's a 20-percent discount, but is it a loser for you?

Mr. KRONCKE. It just about breaks even.

Senator SPECTER. Just about breaks even. How about private insurance companies?

Mr. KRONCKE. We make a profit on some of those.

Senator SPECTER. How much?

Mr. KRONCKE. I really don't have the figure in front of me.

Senator SPECTER. So the way the economics line up, you lose money on what the Government pays for, you break even on what Blue Cross/Blue Shield pays for, and you make money on the private insurers.

Mr. KRONCKE. Yes.

Senator SPECTER. Why do you do business with Blue Cross/Blue Shield if you can't make some money with them?

Mr. KRONCKE. They are the largest provider in the Philadelphia area.

Senator SPECTER. And they bargain in a tough way and you just can't do any better.

Mr. KRONCKE. Well, all the hospitals get together and try and bargain, but once they start to sign the contract, you are left with

the possibility of trying to collect the money from the parents, which is almost impossible, and it does create problems as far as the operation of the institution is concerned.

Senator SPECTER. Do you think it's fair to have a system where the private insurers end up paying more than Blue Cross/Blue Shield pays?

Mr. KRONCKE. I don't think it's fair where you have a system where you have two parties that don't pay the cost of the service that is provided.

Senator SPECTER. What parties do you mean, the Federal Government and Blue Cross/Blue Shield?

Mr. KRONCKE. Federal Government and—for instance, in the State of Pennsylvania—

Senator SPECTER. That's not fair, that's not fair to the hospital, not fair to the system. How do you think that plays out in terms of fairness to the other private insurers?

Mr. KRONCKE. I'm a believer in free enterprise; I realize it causes them problems, but I think they can—

Senator SPECTER. So fairness is an irrelevant question? It's a matter of bargaining power and muscle.

Mr. KRONCKE. I would say so. Certainly the Government has it.

Senator SPECTER. When you have discussed with us your losses, where does that money come from? Where do you pay that out of, donations, contributions?

Mr. KRONCKE. We are a charity, yes; there are two areas that the deficit came from last year. About \$2 million was raised in funds, giving to the hospital, and about \$1.6 million I think was raised through the endowment funds, through the investment of our endowment funds.

Senator SPECTER. So you are able to make up the deficit with contributions.

Mr. KRONCKE. In some years.

Senator SPECTER. Have you failed to do so in some years?

Mr. KRONCKE. Yes, we have.

Senator SPECTER. And what do you do then?

Mr. KRONCKE. We dip into depreciation funds, any funds we can—dip into the endowment—pay the bills.

Senator SPECTER. Depreciation funds, you say?

Mr. KRONCKE. Depreciation funds, yes.

Senator SPECTER. What's a depreciation fund? Is that actual cash?

Mr. KRONCKE. It can be, yes.

Senator SPECTER. You mean moneys that you have set aside to rebuild?

Mr. KRONCKE. To replace the facility.

Senator SPECTER. Well, you run a magnificent hospital, Mr. Kroncke; it's a great public contribution, it's a great institution in Philadelphia.

And you certainly face enormous problems. There are overwhelming problems with the medical industry generally; we have only touched on a very limited fraction of it here today.

The Congress is wrestling with these problems on Medicare and Medicaid and in the tax bills and in so very many lines, and this

hearing has been helpful, at least to me, in exploring and understanding a part of the range of the problems.

Would anybody care to add anything further before we conclude the hearing?

Mr. HURLEY. Senator, if I may, just a couple of points about Mr. Rule's comments and, at the same time, respecting Mr. Kroncke's solutions and his problems.

First of all, it's important to note, I think, that there are two kinds of competition we are talking about here within the health care financing field. One is the competition among the insurers, the private insurance companies, which is intense and it's on many levels. The other kind of competition is the competition among the payers, between the self-funded plans, employers who fund their own health care, Blue Cross plans, ourselves, and other entrants into the field, such as HMO's. It's that kind of competition that has the most potential for abuse, it seems to me, under the current system.

Mr. Kroncke has pointed out to you right here what the inequities are in his particular hospital, and that is repeated in most of the Northeastern States in the urban areas.

Senator SPECTER. But what do we do about it? Is it something more or less than the free enterprise system?

Mr. HURLEY. It seems to me that it is a very serious deficiency in the free enterprise system because the hospitals don't have any competitive pressure; there is always the safety valve, I should say. The safety valve is the private insurance company. If they can't get enough reimbursement from Blue Cross because of their muscle, if they can't get enough reimbursement from the Federal Government and the State government because of tight budgetary controls, they go to us and raise the charges.

Senator SPECTER. Well, it sounds to me, Mr. Hurley, that most of their deficit has come from endowments or from other sources.

How much, Mr. Kroncke, has come from the profits from the private insurance companies, how much of your deficit?

Mr. KRONCKE. I would have to guess at this point in time, between probably 7 and 10 percent.

Senator SPECTER. It would be useful to the committee if you could give us some more precise figures in line with the issue that Mr. Hurley raises. We would be interested to know how much you lose from the Federal Government, how much you make or lose from Blue Cross, specifically as opposed to the generalization of about breaking even, how much you profit from private insurance companies, and how much you pick up on the deficit from other sources.

Mr. Dorsch, we haven't called on you today. Would you care to add anything before we conclude this hearing?

Mr. DORSCH. Thank you, Mr. Chairman, I think this hearing has been most enlightening. I think it underscores what we are trying to do in supporting this bill, that what we really want is to enable competition to grow and to flower, and that we feel the bill does in fact provide the safeguards for the Attorney General so that anything that is truly anticompetitive is not allowed, and so that insurers can do their part in the problem that is a problem facing all of us.

Senator SPECTER. Let me ask you one final question, Mr. Reese.

Is it realistic or helpful at all to have the availability of these advisory letters from the FTC and the Department of Justice so that your group might get together and propose activities which would be permitted under S. 2051 but, in the absence of passage—and we know the tortuous process—we have had a very interesting bill on research and development before the Judiciary Committee which practically everybody agrees to—in fact, everybody does agree to it—but somehow we can't seem to get it passed; a number of us have been really pushing hard on that limited exception, research and development. It is a very tortuous process, given the business of the Congress. And we are just starting in our analysis of the legislation which we have before us.

So my question to you, Mr. Reese, is, Is it realistic to look to a letter or approval by the regulatory bodies, FTC and Justice, to enable you to accomplish some of the objectives which might be sought under S. 2051?

Mr. REESE. Mr. Chairman, as you know, I am not an attorney, and this could perhaps be better answered—

Senator SPECTER. Quite an advantage.

Mr. REESE [continuing]. By attorneys. However, if they would be happy to give us a letter that would let us band together to negotiate prospective costs and payment and free us from an antitrust problem, we would be delighted to receive that.

Senator SPECTER. Well, Mr. Reese, I think that's something that might be pursued. You have Mr. Muris and Mr. Rule saying that they understand the problems and they are sympathetic to the specific situation. They are reluctant to see a permanent change in the antitrust laws which would grant exemptions beyond their control, but it may be that in the context of the specific problems which you face that it could be put in written form and submitted and received as an advisory opinion as to how you might go about solving the problems which you have described here today.

I think that's a fair statement, isn't it, Mr. Rule, Mr. Muris?

Let the record show that both nodded yes.

Mr. HURLEY. I would just interject that I hope that in the case of the Justice Department it will take less than the 2 years it took them to finalize the Maryland Health Care Coalition business review letter which we participated in.

Mr. DORSCH. Senator, I would also like to add, if you don't mind—the nub of the problem isn't simply sharing the data; the problem also goes further with what do you do with the data after you have shared it and how can you get one hospital to negotiate.

Senator SPECTER. I understand that, Mr. Dorsch, and I think negotiations are encompassed in what Mr. Muris and Mr. Rule have said.

They are prepared to take a look at it in the specific context that you have here. Their concern is to have broader exemptions which would cause them problems beyond what is posed here today.

Thank you very much, gentlemen; the hearing is concluded.

[The hearing adjourned at 11:22 a.m.]

[Prepared statement and letter follows:]



THE CHILDREN'S HOSPITAL OF PHILADELPHIA

34th STREET AND CIVIC CENTER BOULEVARD • PHILADELPHIA, PA. 19104 • (215) 596-9100

COMMITTEE ON THE JUDICIARY
TUESDAY, JUNE 26, 1984

TESTIMONY REGARDING SENATE BILL 2051
THE HEALTH CARE COST CONTAINMENT ACT
BY

NOEL E. KRONCKE, PRESIDENT, THE CHILDREN'S HOSPITAL OF PHILADELPHIA

MY NAME IS NOEL E. KRONCKE. I AM PRESIDENT OF THE CHILDREN'S HOSPITAL OF PHILADELPHIA, THE COUNTRY'S FIRST HOSPITAL DEVOTED TO SICK CHILDREN. I HAVE SPENT 24 YEARS IN HEALTH CARE, THE LAST 4½ AS CHIEF EXECUTIVE OFFICER OF PHILADELPHIA'S CHILDREN'S HOSPITAL. PRIOR TO THAT TIME I SPENT ALMOST A DECADE AS ADMINISTRATOR OF THE CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER HERE IN WASHINGTON.

I WOULD LIKE TO EXPRESS MY APPRECIATION FOR THE OPPORTUNITY TO APPEAR BEFORE THE COMMITTEE ON THE JUDICIARY AND AIR MY VIEWS ON THE PROPOSED HEALTH CARE COST CONTAINMENT ACT OF 1983. FURTHER, I WOULD LIKE YOU TO KNOW THAT THE BOARD OF MANAGERS AT THE CHILDREN'S HOSPITAL, OUR MEDICAL STAFF AND ADMINISTRATION SHARE YOUR GROWING CONCERN ABOUT RISING HEALTH CARE COSTS. HOWEVER, WE HAVE GREAT DIFFICULTY IN AGREEING WITH TRENDS WE SEE DEVELOPING IN THE NAME OF COST CONTAINMENT.

LET ME SET THE SCENE FOR YOU. THERE ARE 131 CHILDREN'S HOSPITALS IN THE UNITED STATES. THEY ANNUALLY CARE FOR 500,000 PATIENTS AND PROVIDE 3.7 MILLION DAYS OF INPATIENT CARE. THESE PEDIATRIC INSTITUTIONS DOCUMENT MORE THAN 4.8 MILLION AMBULATORY VISITS ANNUALLY. THE INSTITUTIONS' REVENUES AMOUNT TO 2.1 BILLION DOLLARS; THEIR EXPENSES, 2.3 BILLION.

THE CHILDREN'S HOSPITALS ARE SUBSTANTIAL CONTRIBUTORS TO THE ECONOMY THROUGH THEIR PURCHASES AND PAYROLL TAXES. THE TOTAL EXPENSES OF ALL CHILDREN'S HOSPITALS COMPRISE ABOUT 2 PERCENT OF THE TOTAL EXPENSES OF ALL THE HOSPITALS IN THE UNITED STATES. THIS MAY SOUND RELATIVELY INSIGNIFICANT UNTIL YOU THINK ABOUT THE NATION'S CHILDREN, THEIR HEALTH AND THE COST TO THE TAX-PAYERS OF THE FUTURE IF WE SHOULD

ALLOW THEM TO GROW INTO CHRONICALLY ILL TEENAGERS AND ADULTS WHO CAN'T TAKE THEIR PLACES AS PRODUCTIVE CITIZENS IN A VITAL COUNTRY. THEY WILL BE A BURDEN TO SOCIETY.

MANY CHILDREN'S HOSPITALS ARE LOCATED IN UNDERSERVED URBAN AREAS. FOR EXAMPLE, OURS IS IN A HEAVILY POPULATED PART OF PHILADELPHIA. WE ARE THE FAMILY PEDIATRICIANS TO CHILDREN IN WEST AND SOUTHWEST PHILADELPHIA WHERE ONLY A FEW DOCTORS ARE IN PRIVATE PRACTICE. LAST YEAR WE HAD MORE THAN 150,000 AMBULATORY VISITS. WE HAD 11,472 ADMISSIONS TO OUR BEDS. WE RUN AN AVERAGE OF 85 PERCENT OCCUPANCY. FORTY PERCENT OF OUR BEDS ARE ALLOCATED TO INTENSIVE CARE. OUR NEWBORN INTENSIVE CARE UNIT, WHICH WAS THE FIRST IN THE NATION, HAS A RATE OF ONE NURSE TO EVERY ONE AND ONE-HALF BEDS. EXPENSIVE CARE? YES, OF COURSE. BUT WE HAVE CONDUCTED POST HOSPITALIZATION STUDIES AND HAVE BEEN ABLE TO DEMONSTRATE THAT FOR THE MOST PART THE INFANTS WHO ARE RECEIVING THIS CARE ARE GROWING INTO HEALTHY NORMAL CHILDREN.

THE CHILDREN'S HOSPITAL OF PHILADELPHIA IS THE ONLY ONE IN PENNSYLVANIA PROVIDING GROSSLY MALFORMED CHILDREN WITH CRANIOFACIAL REPAIR. THE TECHNIQUES FOR THIS COMPLICATED PROCEDURE WERE DEVELOPED BY OUR SURGEONS. WE ARE ONE OF TWELVE HOSPITALS IN THE UNITED STATES DOING PEDIATRIC BONE MARROW TRANSPLANTS, AS WELL.

WE HAVE THE ONLY CARDIOTHORACIC SURGEON IN THE UNITED STATES CURRENTLY PERFORMING SURGERY FOR CERTAIN DEFECTS IN BABIES WHO ARE UNDER ONE MONTH OF AGE. ON MONDAY OF LAST WEEK WE SEPARATED CONJOINED BABY GIRLS WHO CAME TO US FROM WISCONSIN. TEN DAYS BEFORE THAT REMARKABLE OCCASION, ANNOUNCEMENT WAS CARRIED BY THE MEDIA NATIONALLY THAT WE HAD COMPLETED SUCCESSFUL CLINICAL TRIALS OF A NEW VACCINE TO PREVENT CHICKEN POX DEVELOPED BY A PHARMACEUTICAL COMPANY. WE CAN NOW LOOK FORWARD TO ERADICATING THAT POTENTIALLY DANGEROUS DISEASE IN THE NEXT FIVE TO TEN YEARS. OUR INSTITUTION HAS PLAYED A MAJOR ROLE IN DISEASE PREVENTION-- THE FIRST VACCINES AGAINST MUMPS, INFLUENZA AND WHOOPING COUGH WERE DEVELOPED AT THE PHILADELPHIA CHILDREN'S HOSPITAL. IN MID-MAY THE WALL STREET JOURNAL PUBLISHED A FRONT PAGE STORY ON OUR CANCER PROGRAM. YES, ALTHOUGH CANCER IS A RARE DISEASE AMONG CHILDREN, WE ACTUALLY CARE FOR 1,000 CHILDREN EACH YEAR WHO ARE AFFLICTED WITH THE AILMENT.

THE WORK WE DO IS EXPENSIVE, BUT AS I HAVE POINTED OUT, IT CONTRIBUTES TO THE HEALTH OF CHILDREN AROUND THE WORLD. WE SERVE AS A REGIONAL REFERRAL MEDICAL CENTER WITH PATIENTS COMING TO US LAST YEAR FROM 22 STATES AND 11 FOREIGN COUNTRIES. TWENTY-FOUR PERCENT OF OUR INPATIENTS ARE NEW JERSEY RESIDENTS. I TELL YOU ALL OF THIS BECAUSE HOSPITALS LIKE OURS MAINTAIN PATIENT CARE PROGRAMS THAT SAVE OTHER HOSPITALS FROM DUPLICATING MANY OF OUR SERVICES, CONDUCT RESEARCH THAT AFFECTS THE HEALTH OF THE NATION AND OPERATE TEACHING PROGRAMS THAT SUPPLY THE COUNTRY WITH HIGHLY QUALIFIED PEDIATRICIANS AND SURGICAL SPECIALISTS WHO IMPROVE THE HEALTH OF OUR YOUNGSTERS.

THERE IS A MAJOR PROBLEM, HOWEVER. LAST YEAR THE PARENTS OF OUR PATIENTS, MOST OF WHOM ARE VERY YOUNG, LEFT US WITH A 7.8 MILLION DOLLAR LOSS IN BAD DEBTS AND CHARITY. OF THIS AMOUNT, 3.5 MILLION DOLLARS WAS LOST IN INADEQUATE MEDICAID REIMBURSEMENT. OUR BUDGET OF 67.7 MILLION DOLLARS WAS METICULOUSLY PLANNED, CAREFULLY ADHERED TO, BUT ABUSED BECAUSE OF THESE BAD DEBTS. WHEN HEALTH CARE COSTS ARE CRITICIZED, THE COST OF LABOR IS RARELY MENTIONED. MOST PEOPLE ARE NOT AWARE THAT 65 CENTS OF EVERY DOLLAR IS SPENT ON LABOR. FORTY-NINE PERCENT OF OUR PATIENTS ARE UNDER THE AGE OF TWO AND ONE-HALF. THEY CAN'T TELL YOU WHEN THEY ARE GOING TO BE SICK TO THEIR STOMACHS. HENCE, HIGHER LINEN BILLS. THEY CAN'T EAT BY THEMSELVES; THEY MUST BE FED, MEDICATED, AND MONITORED. WE HAVE TWENTY-FOUR HOUR VISITING PRIVILEGES BY PARENTS AND A CORPS OF ALMOST 500 DEDICATED VOLUNTEERS, BUT WE STILL NEED PROFESSIONAL HELP TO CARE FOR THESE CHILDREN. BECAUSE THEY ARE SICKER, THEY NEED UP TO 68 PERCENT MORE DIRECT NURSING CARE THAN DO THEIR ADULT COUNTERPARTS WHO ARE HOSPITALIZED. THE MORE HELP; THE GREATER THE EXPENSE.

NO ONE EVER MENTIONS THE EXTRA MONEY IT COSTS TO DELAY PAYMENT OF OUR BILLS BECAUSE OUR REIMBURSEMENT FROM THE GOVERNMENT IS FREQUENTLY LATE, OR BECAUSE PARENTS DON'T PAY ON TIME, EVEN IF THEIR CHILDREN ARE PRIVATE OR SEMI-PRIVATE PATIENTS. INTEREST HAS A WAY OF ACCUMULATING WHEN VENDORS ARE NOT PAID.

YOU MAY WANT TO COUNTER THIS COMMENTARY BY SAYING THE NEW PROSPECTIVE PAYMENT SYSTEM WILL SOLVE THIS PROBLEM. NOT SO IN OUR CASE, OR IN THE CASE OF SEVERAL OTHER STATES IN THE UNION.

WHILE THE FEDERAL GOVERNMENT EXEMPTED PEDIATRIC HOSPITALS FROM ITS NEW DRG OR PROSPECTIVE PAYMENT SYSTEM UNTIL JANUARY, 1985, WHEN THE NATION'S CHILDREN'S HOSPITALS WILL HAVE DESIGNED A PEDIATRIC DRG SYSTEM, OUR COMMONWEALTH HAS ELECTED TO INCLUDE ITS CHILDREN'S HOSPITALS IN THE NEW REIMBURSEMENT METHOD. WE WILL LOSE AN ADDITIONAL 1.5 MILLION DOLLARS THE WAY THE FORMULA HAS BEEN PRESENTED. IT GOES INTO EFFECT FOUR DAYS HENCE, JULY 1st. MANY HOSPITALS PROVIDING TERTIARY CARE IN URBAN AREAS FACE THE SAME DILEMMA; COMMUNITY HOSPITALS MAY NOT HAVE THE SAME PROBLEM.

IT IS UNDERSTANDABLE THAT PRIVATE INSURERS ARE BEGINNING TO SUSPECT THEY WILL BE CALLED UPON MORE FREQUENTLY TO PAY FOR THE LOSSES EXPERIENCED BY SOME HOSPITALS. THEY INTEND TO RESIST THE "ROB PETER TO PAY PAUL" PRINCIPAL THAT WILL INCREASE AS THEY REIMBURSE HOSPITALS FOR THE CARE OF THEIR PATIENTS. I WOULD LIKE TO POINT OUT THAT HEALTH CARE AS WE KNOW IT TODAY IS NOT THE HEALTH CARE OF A DECADE AGO. WHEN HEALTH CARE WAS FIVE PERCENT OF OUR GROSS NATIONAL PRODUCT, IT WAS NOT THE WORLD OF MEDICINE AS WE NOW KNOW IT. TEN YEARS AGO CHILDREN WITH LEUKEMIA DIED, OFTEN WITHIN SIX MONTHS OF DIAGNOSIS OF THE DREAD DISEASE. TODAY, FIFTY PERCENT OF SUCH CHILDREN ARE CURED. ANOTHER EXAMPLE OF WHAT A HOSPITAL LIKE OURS PROVIDES ALL OUR CHILDREN: IN 1963 MRS. JACQUELINE KENNEDY GAVE BIRTH TO A SON WHO WAS PREMATURE AND WHO DEVELOPED RESPIRATORY DISTRESS SYNDROME. ALTHOUGH THE PRESIDENT'S SON WAS AT ONE OF THE FINEST PEDIATRIC INSTITUTIONS IN THE WORLD, HE SUCCUMBED AFTER SEVERAL DAYS. TODAY, BABIES FAR SMALLER AND MORE PREMATURE THAN THAT ILL-FATED INFANT ARE SAVED AND GIVEN THE OPPORTUNITY FOR A NORMAL EXISTENCE. ANOTHER INSTANCE: TEN OR TWELVE YEARS AGO THE PREDICTED DEATH RATE FROM SICKLE CELL ANEMIA, A DISEASE THAT AFFLICTS ONE OUT OF EVERY 400 BLACKS, WAS 10 PERCENT IN THE FIRST YEAR OF LIFE. IN THE 12 YEARS OUR COMPREHENSIVE CENTER FOR THIS DISEASE HAS BEEN IN EXISTENCE, NOT ONE SINGLE CHILD WITH SICKLE CELL ANEMIA UNDER ONE YEAR HAS DIED. A DECADE AGO MORE THAN 99 PERCENT OF OUR SURGICAL PROCEDURES REQUIRED OVERNIGHT STAYS IN THE HOSPITAL. TODAY MORE THAN HALF OF THOSE OPERATIONS ARE PERFORMED IN DAY SURGERY SAVING THOUSANDS OF FAMILIES THE ANGUISH OF SEPARATION AND THOUSANDS AND THOUSANDS OF DOLLARS.

THE CAT SCANNER, MUCH MALIGNED BECAUSE OF ITS 750,000 DOLLAR COST, HAS SAVED COUNTLESS DOLLARS BECAUSE THE OLD-TIME PRACTICE OF OPENING A HEAD FOR COSTLY EXPLORATORY BRAIN SURGERY CAN BE AVOIDED IN MOST INSTANCES, ONE CAN NOW DIAGNOSE BRAIN TUMORS IN THE RADIOLOGY DEPARTMENT INSTEAD OF THE OPERATING ROOM.

I BELIEVE THAT HEALTH COSTS ARE UP FOR GOOD REASON, BUT I BELIEVE THAT GETTING A WAIVER TO THE SHERMAN ANTI-TRUST ACT WILL NOT SOLVE THE PROBLEM. INSTEAD, I WOULD ASK THE PRIVATE INSURANCE COMPANIES TO TAKE A BROAD STEP BY LOOKING INTO MEDICAL PROGRESS AND REALIZING THAT THEY WILL SAVE MONEY BY REIMBURSING FOR EXTENDED CARE AND HOME CARE. A CASE IN POINT: OUR TECHNOLOGY HAS ENABLED US TO PLACE SOME CHILDREN ON MECHANICAL VENTILATORS TO BREATHE. MANY OF THESE YOUNGSTERS ARE NORMAL IN EVERY WAY EXCEPT FOR THEIR DEPENDENCY ON MECHANICAL BREATHING DEVICES. IT COSTS ABOUT \$250,000 TO KEEP SUCH A CHILD IN THE HOSPITAL. THERE IS A POINT WHERE HOSPITALIZATION IS NOT BENEFICIAL, BUT SENDING THE CHILDREN HOME IS VIRTUALLY IMPOSSIBLE BECAUSE THE PARENTS' INSURANCE WILL NOT REIMBURSE THEM FOR HOME CARE, ALTHOUGH THE COST IS APPROXIMATELY 65 TO 75 PERCENT LESS. WE HAVE FOR SOME YEARS APPROACHED INSURANCE COMPANIES, THE LARGER ONES, ON A ONE-TO-ONE BASIS TO SECURE THE NECESSARY EXEMPTIONS. IT HAS TAKEN AN ENORMOUS INVESTMENT OF TIME BY THE PHYSICIAN IN CHARGE OF THESE CHILDREN TO ACHIEVE SUCCESS. IMAGINE THE MILLIONS THAT COULD BE SAVED IN THAT ONE AREA ALONE WERE INSURANCE COMPANIES TO BEGIN THINKING ABOUT COVERING ALTERNATIVE SYSTEMS TO HOSPITALIZATION.

I WOULD LIKE TO CHALLENGE THE INSURANCE COMPANIES TO WORK TOGETHER ON A PILOT PROJECT, PERHAPS WITH SEVERAL CHILDREN'S HOSPITALS TO SEE JUST HOW MUCH MONEY COULD BE SAVED BY DEVELOPING INSURANCE PLANS THAT WOULD INCLUDE COVERAGE OF EXTENDED CARE FACILITIES, HALF-WAY HOUSES, GROUP BOARDING SERVICES AND HOME CARE. OUR OWN EXPERIENCE WITH THE VENTILATOR-DEPENDENT CHILDREN DEMONSTRATES THAT IT CAN REDUCE HOSPITAL UTILIZATION. WHY CAN'T THE INSURANCE COMPANIES MAKE A SPECIAL EFFORT ON BEHALF OF THE CHILDREN, THE NATION'S MOST PRECIOUS RESOURCE AND SEE WHAT CREATIVE THINKING WILL DO, NOT ONLY TO CONTAIN HEALTH CARE COSTS, BUT TO SAVE DOLLARS IN THE FUTURE BECAUSE THE YOUNGSTERS WILL GROW INTO HEALTHY ADULTS.

LOOK AT REIMBURSEMENT FOR ADULTS. IF THE PRIVATE INSURANCE COMPANIES IS SIMILIAR TO THE GOVERNMENT'S, IT IS DISPROPORTIONATE. THE AGED, WHO COMPRISE 11 PERCENT OF THE POPULATION RECEIVE ABOUT 38 PERCENT OF MEDICAID DOLLARS. CHILDREN, WHO OCCUPY 31 PERCENT OF THE POPULATION UTILIZE 19 PERCENT OF THE SERVICES FUNDED UNDER MEDICAID (THE REMAINING PERCENTAGES: AFDC FOR ADULTS, 16; BLIND AND DISABLED, 27). IT IS

INTERESTING TO NOTE THAT THE BRITISH GOVERNMENT * SPENDS 10 PERCENT MORE ON CHILDREN THAN THE AGED: IN GENERAL, THE UNITED STATES SPENDS 63 PERCENT LESS ON CHILDREN THAN ON ITS OLDER CITIZENS. PLEASE DON'T MISUNDERSTAND ME. I AM TOTALLY SUPPORTIVE OF SERVICES TO THE COUNTRY'S OLDER PEOPLE. I APPLAUD AS WELL THE EFFORTS BEING MADE IN PREVENTIVE HEALTH, PARTICULARLY IN TERMS OF IMPROVED PREGNANCY OUTCOME. BUT WHAT OF THOSE WHO ARE SICK CHRONICALLY OR HANDICAPPED, PARTICULARLY THE CHILDREN?

INSTEAD OF PERMITTING INSURANCE COMPANIES TO BAND TOGETHER IN THE NEGATIVE SENSE TO SEEK A WAIVER TO THE SHERMAN ANTI-TRUST ACT, WHY NOT ENCOURAGE COMPETITION AMONG OUR INSURERS SO THAT THEY CAN DEVELOP ATTRACTIVE PLANS FOR PEOPLE WITH YOUNG FAMILIES, PLANS THAT WILL SAVE MONEY FOR BUSINESSES OFFERING HEALTH CARE AS A BENEFIT TO THEIR EMPLOYEES BECAUSE THE POLICIES WILL INCLUDE STEP-DOWN CARE, ENCOURAGE EARLY DISCHARGE FROM HOSPITALS AND HAVE A MAJOR IMPACT ON THE HEALTH OF THE NATION AND THE HEALTH OF OUR ECONOMY.

THANK YOU.

* HENRY J. AARON, (CO-AUTHOR OF PAINFUL PRESCRIPTION: RATIONING HOSPITAL CARE) QUOTED IN WASHINGTON ACTIONS ON HEALTH, MAY 21, 1974, PUBLISHED BY CAPITOL PUBLICATIONS, INC.



FOUNDED 1855

THE CHILDREN'S HOSPITAL OF PHILADELPHIA

34th STREET AND CIVIC CENTER BOULEVARD • PHILADELPHIA, PA. 19104 • (215) 596-9100

July 18, 1984

Senator Arlen Specter
 SH 331
 Hart Senate Office Building
 Washington, DC 20510

Dear Senator Specter:

During the June 26th hearing before the Committee on the Judiciary you made a request of me. You asked how much money we lose from the federal government, how much we made up or lost from Blue Cross (specifically as opposed to the generalization about breaking even), how much we profit from private insurance companies and how much we picked up on the deficit from other sources.

Here are the answers for the year ending June 30, 1983. (Our statistics for this year are not yet complete.)

- 1) we lost \$4,354,000 because of inadequate reimbursement for Medicaid services, which is a combined federal and state program
- 2) we gained \$91,000 from Blue Cross reimbursement
- 3) we made \$4,461,000 above cost from the private insurance companies (but we lost \$1,093,000 from the self-pay patient services) and
- 4) we had a total operating loss of \$895,000, a huge improvement over fiscal year 1982 when we lost \$4,000,000.

We were able to raise \$1,670,000 in unrestricted contributions and \$2,300,000 in dividends and interest in endowments.

We have been able to hold down expenses, increase our charges and improve our medical information system to better capture our financial information. These facts plus the improvement in the investment picture have enabled us to compensate for some of the inadequacies in reimbursement.

I would remind you that our costs are exceedingly high because children's hospitals, particularly one like ours with more than 40 percent of its beds allocated to tertiary (intensive and specialized) care are labor - intensive. In addition, most young families cannot afford the bills resulting from the problems that accompany critical illnesses.

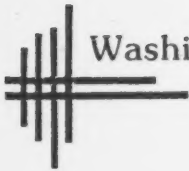
I want to thank you for the opportunity to testify against S. 2051 - the Health Cost Containment Act. I appreciated having my views heard.

Sincerely,

Noel E. Kroncke
 President

NEK:cfh

APPENDIX



Washington Business Group on Health

S. 2051

The Health Care Cost Containment Act of 1983

Testimony by

Willis B. Goldbeck
President

Washington Business Group on Health

On behalf of the members of the WBGH, it is my pleasure to accept your invitation to comment upon S. 2051, the Health Care Cost Containment Act of 1983. You are to be commended for taking on this complex and contentious issue.

Members of the Washington Business Group on Health purchase the medical care benefits for some 50,000,000 employees, retirees and dependents. Added to these costs are contributions to Medicare, disability, sick pay, corporate medical departments and a vast array of non-insured health programs. You can easily see that we appreciate the medical care cost problem.

Before dealing with our specific recommendations on S. 2051, I would like the record to reflect that there is no need for legislation to achieve two of the three objectives.

First, the current antitrust laws do not stop any insurance carrier or employer from collecting, analyzing, or reporting on price, utilization or quality data. This is happening now in many communities and, although the lead in developing data systems has not come from insurers, there never has been any legal impediment to their participation.

The legislative issue about data collection is the need to override provider resistance. We need the Professional Review Organization

regulations to guarantee access to both hospital and physician-specific price, utilization and quality information. We would also welcome the Senate's support for the Wyden amendment to H.R. 5602. This amendment, so strongly opposed by some medical groups yet supported by a coalition of the American College of Physicians, National Association of Manufacturers, AFL-CIO, AARP and the WBGH, would assist state and local governments, unions, employers and large consumer groups in obtaining and responsibly using comparative data.

The problem with data is not antitrust, it is the lack of trust exhibited by providers who are trying to hide the truth from the public.

Second, antitrust does not appear to be a barrier to the collection or distribution of insurance claims. Employers can share claims information if they wish. Carriers can share information and are encouraged by the DHHS Inspector General's office to do so in the nationwide effort to identify fraudulent providers. Antitrust would be an issue if the collected claims were used to distort the market, reduce real economic competition or support conspiracy. These actions are not desirable, nor should they be exempt. However, if we can access and share comparative information, the result will be increased competition and more efficient services.

What the agencies responsible for antitrust enforcement must understand is that more competition in the medical industry will result in business failures. That is one inevitable -- and desirable -- result of the whole cost management effort.

Congress can help prevent future lawsuits and give encouragement to purchasers and carriers by making clear its understanding of the appropriateness of the economic pressures sure to result from information collection and disclosure. An exemption is not needed, only an appreciation for the values of increased market forces and the predictable economic consequences.

Finally, we come to the issue of negotiating. Here the proposed exemption may be helpful. We would want to be certain that nothing in S. 2051 is exclusively offered for insurance carriers. Employers, unions and third party administrators including those who represent public employees are of greater importance.

To be certain that the exemption does not do more harm than good we recommend the following:

1. Sunset the bill after five years. A period of that length is needed to get a true measure of market impact.
2. Establish a non-judicial arbitration process for cases that arise during the five years and meet an established criterion for emergency conditions. The bankruptcy of a facility predominantly serving a minority population might be such a case.
3. Require and fund a comprehensive study of the exemption's impact. The study, conducted through DHHS, should have a management board including representatives of the FTC, and Departments of Justice, Labor and Commerce.
4. Limit the exemption to aggregations of purchasers in which none represents more than 15 percent of the market and the collective represents no more than 35 percent of the market.

With these protections, S. 2051 could make a major contribution to our understanding of the medical market and the potential that collective action may have upon cost management.

Thank you for your leadership on this issue and for soliciting the opinions of the Washington Business Group on Health.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

STATEMENT FOR THE RECORD

BY

ROBERT B. HELMS, PH.D.

ACTING ASSISTANT SECRETARY FOR PLANNING AND EVALUATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman and members of the Committee: I am pleased to have this opportunity to participate in this discussion of health care cost containment strategies.

When the Reagan Administration came to HHS in 1981 we declared that a new approach to health policy was necessary to deal with the health cost problem. We developed strategies for containing health care costs that are designed to make every participant more cost conscious. From the consumer to the employer who pays the bill, from the insurance carriers to the government programs, each should become a more prudent buyer and user of health care, and each should bear some risk of unnecessary health spending.

The Administration rejects the notion that increased government regulation is the appropriate or most effective means for controlling health care costs. We believe that there are changes that can be made in the Medicare program -- to complement the prospective payment system -- and changes that can be made in Federal tax policy that will provide strong incentives for efficiency in the delivery of health care without intruding into patient-provider relationships or threatening the high quality of care.

DEFINING THE PROBLEM

You all are well aware of the magnitude and persistence of the health cost problem. The share of the nation's GNP going to health care has grown from about 7.9% in 1972 to 10.7% in 1983. The Federal investment in Medicare and Medicaid has grown so large that it is becoming a serious burden on the Federal

budget and the U.S. economy. Between 1970 and 1980, Medicare spending almost doubled as a percentage of gross national product. During fiscal year 1984, Medicare will spend \$44 billion for hospital care and \$20 billion for outpatient care.

Similarly, health benefits have consumed an ever larger share of private employee compensation -- approximately \$65.8 billion was spent on employer health insurance benefits in 1982. A few years ago, health insurance was looked upon as a minor and deductible cost of doing business. Today it has become a major financial undertaking of private enterprise, and many employers have chosen to self insure and adopt internal controls on employee health spending rather than rely exclusively on outside organizations.

What concerns me is not simply the number of dollars being spent on health care, but the evidence that the nation's health care system is not as efficient as it should be. For example, there is considerable evidence of wide variations in the costs of health care. In 1982, greater than two-fold differences in per capita cost and use of hospital services existed among states -- health care expenditures per capita ranged from a low of \$278 to a high of \$620, and hospital admissions per 1000 population ranged from 95 to just over 200 admissions. Similar variations were observed in small areas such as adjacent counties in New England where elective surgical rates varied by a factor of two or more. These statistics suggest that a large amount of the inefficiency in the health care system can be improved by applying appropriate incentives. We need not abandon our commitment to high quality health care in the name of making the health care system more efficient. But we must make our health care system more efficient if we are to preserve, and expand, the quality and access gains of the last several decades.

Fortunately, there is cause for some encouragement in recent data on health care expenditure trends. Age-adjusted hospital admission rates per capita and lengths of stay have been declining for some time. The medical care component of the consumer price index is now at levels substantially below those of 1981 and 1982, and the hospital component of the index is below the 10

percent increase level for the first time in several years. In the private sector, employers have begun themselves to undertake the difficult task of reducing private health spending inflation, with indications of success which I will enumerate later. And the early returns of data on hospital performance under prospective payment indicate that the new system is operating as intended.

These encouraging signals are far too preliminary to conclude that the health care cost problem is being solved. But they do indicate that we are on the right track. We need to pursue our course of strengthening purchaser and provider incentives for efficiency in health care delivery and financing. This course offers the most promise of achieving cost containment goals without sacrificing free access to quality health services that Americans demand and expect to receive.

THE NEED TO CHANGE INCENTIVES

Despite significant recent improvements, costs and expenditures continue to rise for several reasons. Comprehensive, first dollar insurance too often hides costs from the view of both the patient and provider. Costs also continue to rise because private and public third-party payers have failed to act as prudent buyers of health services on behalf of their enrollees. Too often, the practice has been to pay virtually whatever is billed by physicians and hospitals, passing the costs on in the form of higher premiums or taxes.

We all recognize, of course, that the primary purpose of insurance is to spread the costs of illness so that concerns about the cost of care do not dominate clinical decisions. Yet it is possible to go too far, and the Administration believes that the public and private health care financing system has gone too far in hiding the cost of health care. Concealing costs to the extent we have has seriously exacerbated the health spending problem.

The end result is that the entire nation pays for the high cost of health care but often in indirect ways -- in higher employer-paid insurance premiums that reduce the financial resources available for increased wages and new jobs; in higher prices

for goods and services to cover cost of the elaborate health plans which are favored by our tax policy; and in higher taxes to support Medicare and Medicaid.

If we are ever to get control of health care inflation, we must correct the "backward" incentives built into our financing and delivery system. Federal health policy is a good place to start, because Federal tax and health programs have done much to hide health care costs and remove incentives for efficiency.

We have made a major step towards correcting these backward incentives through the implementation of prospective payment, which changes Medicare from retrospective cost reimbursement of hospitals to a system of prospectively-determined payments.

The prospective payment system is already having a positive effect on the hospital industry. Most hospitals -- large and small -- are taking a serious and business-like look at their case mix profiles, analyzing practice patterns and costs by DRG and implementing patient management protocols. Hospitals are actively engaging in strategic planning, undergoing internal assessments and evaluating their mission, scope and relationships to the broader health care delivery system within the community. The DRG system has thus created an impetus for applying sophisticated business and management practices.

HHS will continue to collect data to identify how prospective payment of hospitals is working, to design and implement improvements, and to extend the prospective payment concept into new areas of reimbursement. The Department's recommendation on the method for including capital reimbursement under the prospective payment system will be the subject of a report to Congress due in Fall 1984. The Department is also developing recommendations on the feasibility of paying skilled nursing facilities by prospective payment and the feasibility and advisability of including inpatient physician services in the prospective payment system.

In another important change in the Medicare financial system, in May 1984 HCFA published proposed regulations on Medicare payment to Health Maintenance Organizations and Competitive Medical Plans. These regulations expand the definition of entities that may participate in Medicare on a prepayment basis

and authorize Medicare reimbursement on a prospective, per capita basis for those organizations that have a risk contract. Greater participation in Medicare by HMOs and other competitive plans will be encouraged when the regulations are implemented later this year.

LEGISLATIVE PROPOSALS

The Administration's legislative proposals build on the prospective payment legislation and HMO changes mandated under TEFRA. The Federal government's roles in controlling health care costs are to improve the efficiency of Medicare, allow states the flexibility to implement cost containment programs and remove the perverse tax incentives that encourage excessive health benefits. Among the proposals included in the Administration's package of reforms are:

- o a one-year freeze on the fees that Medicare pays physicians, which will slow the rise in Medicare spending while HHS studies longer term reforms in physician reimbursement,
- o a proposal to provide Medicare beneficiaries an opportunity to utilize the dollar value of their benefits by selecting a private health care plan more suitable to their specific needs,
- o a proposal to index the Medicare Part B deductible so that inflation does not steadily erode the deductible's value as a deterrent to unnecessary utilization, and
- o a dollar limit on the tax-free contributions that employers can make toward employee health benefits.

The purpose of the proposed limit on tax-free private health insurance is to stimulate private plans to consider needed reforms in their own benefits and reimbursement rules. Since there is not, in our view, a single "right way" to improve the efficiency of a health benefits program, we would not require private plans to employ any particular cost containment technique. Instead, government's proper role is to limit the tax law's distorting influence on private choices, leaving employment groups to develop

cost containment programs that suit their own needs. In short, the proposed "tax cap" is not a punitive tax on health benefits but rather an effort to make the tax law neutral in the choice between added wages and added health benefits.

DEVELOPMENTS IN THE PRIVATE SECTOR

Before reviewing what the various components of the health market are doing to control health costs, let me review briefly some forces that have led to these private sector efforts.

The most obvious reason that people in the private sector have begun to pay more attention to health care costs was their realization that they could not afford to have health care costs continue to increase at 1970s rates without a devastating impact on government and corporations. This realization that something must be done has been a gradual process over the last five years and has been more intense in some states and sectors of the business community than in others.

Another factor that helped to change private sector attitudes was the realization in the late 1970s that Congress was not going to pass either national health insurance or a stringent regulatory system to control hospital rates. In 1981 Congress gave a strong signal to the states to control their own costs by giving them more flexibility to administer their Medicaid programs and various public health grant programs. The prudent purchaser principle embodied in the Medicare prospective payment system established in the Social Security Amendments in 1983 gave a further indication that Congress supports an incentives-based cost management strategy rather than a regulatory approach.

Recent Congressional actions and the Administration's continued emphasis on health incentives reform transmit a clear message to the private sector -- take a more active and constructive role in designing solutions to the health care cost problems.

The diversity of private sector cost containment strategies is to be applauded and encouraged. The private sector is assuming a critical role in fostering market incentives that will promote cost containment and efficiency in the health care system. The following are examples of private sector cost management

activities that are becoming increasingly evident throughout the country.

- o First, surveys indicate an increase in patient cost-sharing in employer-sponsored health plans. According to the Hay-Huggins Survey of Non-Cash Compensation, about one-third of a broad sample of private firms had recently increased their health insurance deductibles. Another third were considering an increase. These figures are up considerably over the 1982 Survey results. The Rand Health Insurance Experiment, which is financed by my office, shows that cost-sharing can help control the costs of health care without significant adverse health effects.
- o For the individual firm, the impact of cost-sharing can be significant. For example, U.S. Steel dramatically reduced its hospitalization rate for 18,000 salaried employees by adding a \$304 deductible on hospital care. Since 1982, when the deductible was introduced, hospital admissions have decline by 20 percent. Similarly, a \$50 deductible on outpatient emergency visits reduced those visits by one-third.
- o Restructuring health benefits is another major area of private sector cost management activity. Some benefits packages now encourage second-surgical opinions by waiving the usual cost sharing. The Cornell Medical Center-New York Hospital study found that its mandatory second opinion program saved \$2.63 in benefit costs for every dollar expended. CIGNA's second opinion program saved \$2 million over a five year period, yielding an annual saving of \$16 in surgical costs avoided for every dollar spent on consultations.
- o There has been an increase in private utilization review programs and practice pattern monitoring to identify aberrant utilization and pricing patterns. The Iowa Foundation for Medical Care is the largest organization engaged in such activity. Utilization review in Iowa was partially responsible for an unprecedented reduction in private health insurance rates.

- o One of the Iowa Foundation's major clients is John Deere and Company. In less than five years, Deere's inpatient hospital days per 1000 insured declined by 31.2%, yielding a ten-to-one return on its financial investment in utilization review. Similarly, length of stay for San Diego firms participating in a hospital utilization review program is 42 percent lower than for firms not participating in the business coalition-sponsored program.
- o Private cost containment efforts have also included the use of "preferred provider organizations" (PPOs). There are many different types of PPOs, usually the consumer retains a free choice of physician or hospital, although the PPO's sponsor (often an employer) attempts to steer the consumer to lower cost providers who have signed participation contracts with the PPO. The employer steers the consumer by reducing his cost-sharing if he goes to a "preferred" provider. Unlike HMOs, PPOs operate a fee-for-service basis. PPOs seem to achieve cost savings by contracting with providers at fixed rates of payment (often at levels below customary charges) and instituting utilization review programs such as pre-admission certification and discharge planning. Interest in developing PPOs is being expressed by physicians, hospitals, insurers, employers and business coalitions.
- o A related development is the continued growth of HMOs. As you know, HMOs vary in their organizational structure, but what they have in common is a greater integration of health care financing and delivery than the traditional fee-for-service indemnity plans. Recent findings from the Rand study confirm that HMOs significantly reduce the costs of delivering medical care. The calculated expenditure rate was about 25 percent less in the HMO than for the fee-for-service group receiving free care. Further, hospitalization rates for HMO enrollees were 40 percent below the fee-for-service group. These findings can not be attributed to a healthier HMO population.

The 1983 National HMO Census reported that HMO enrollment from June 1982 to June 1983 increased by 15.3 percent. There are 13.6 million members in 290 plans nationwide.

- o More than a dozen Blue Cross and Blue Shield plans now have incentive programs to encourage early maternity discharges. Another two dozen are developing programs or conducting exploratory research to enable more new mothers to return home to their families soon after childbirth. Nationally, the cost saving potential of these programs is significant. If the average hospital stay for a normal delivery were reduced by only one-half day, savings could be between \$40 and \$50 million.
- o On June 13, 1984, the Blue Cross and Blue Shield Association announced guidelines designed to limit diagnostic CAT-scans, X-rays, ultrasound, thermography and other techniques that produce images of internal organs. They expect these guidelines to produced millions of dollars of savings annually.
- o Health promotion is another area of growing interest among employers. The Washington Business Group on Health reports that the majority of its 200 member firms currently offer some form of health promotion or employee education program.

CONCLUSION

As you can see Mr. Chairman, there is reason to be encouraged about the future. Nevertheless, while these activities are exemplary of the kinds of innovations being developed in the private sector, they are not necessarily representative of private health care financing taken as a whole. Regrettably, there remains a great deal of inefficiency in health care financing that continues to be supported by the current tax system. We need to install incentives that will make private cost containment commonplace. By doing so, we can insure that public and private progress in reducing health spending inflation is mutually reinforcing and consistent.

Now is not the time to rest, nor is it time to change direction. I believe these private sector efforts coupled with the recently enacted Medicare prospective payment system and earlier improvements in Medicaid represent a good start in slowing health care inflation. I wish to emphasize my belief that private decisions, motivated by the appropriate incentives, offer the greatest potential for bringing the health spending problem under control. This is why I have emphasized private sector cost containment activities in my remarks. I hope Congress and the Administration can build on the foundation that has been laid by reaching agreement on a package of reforms that stimulate still more purchaser and provider efforts at cost containment.

■ ■ ■

